SERFF Tracking Number:	*GHPI-125840691*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Company*	*State Tracking Number:*	*40412*
Company Tracking Number:	*INDPPO08CHL*		
TOI:	*H15I Individual Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15I.001 Health - Hospital/Surgical/Medical Expense*
Product Name:	*AR Individual PPO*		
Project Name/Number:	*/*		

Filing at a Glance

Company: Coventry Health and Life Insurance Company

Product Name: AR Individual PPO	SERFF Tr Num: GHPI-125840691	State: ArkansasLH
TOI: H15I Individual Health - Hospital/Surgical/Medical Expense	SERFF Status: Closed	State Tr Num: 40412
Sub-TOI: H15I.001 Health - Hospital/Surgical/Medical Expense	Co Tr Num: INDPPO08CHL	State Status: Approved-Closed
Filing Type: Form/Rate	Co Status:	Reviewer(s): Rosalind Minor
	Authors: Geneva Clark, Anita Carter	Disposition Date: 10/07/2008
	Date Submitted: 10/01/2008	Disposition Status: Approved
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile: Not Filed
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 01/16/2009	
State Status Changed: 01/16/2009	Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

This is a filing for documents to be used with an individual Preferred Provider Organization (PPO) product.

Company and Contact

SERFF Tracking Number:	*GHPI-125840691*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Company*	*State Tracking Number:*	*40412*
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Product Name:	*AR Individual PPO*		
Project Name/Number:	*/*		

Filing Contact Information

Anita Carter, Manager of Regulatory Compliance
550 Maryville Centre Drive
St. Louis, MO 63141-5818

acarter@cvty.com

(314) 506-1928 [Phone]
(314) 506-1672[FAX]

Filing Company Information

Coventry Health and Life Insurance Company
6705 Rockledge Drive
Suite 900
Bethesda, MD 20817
(314) 506-1700 ext. [Phone]

CoCode: 81973
Group Code: 1137

Group Name:
FEIN Number: 75-1296086

State of Domicile: Delaware
Company Type:

State ID Number:

Filing Fees

Fee Required?	No
Retaliatory?	No
Fee Explanation:	
Per Company:	No

SERFF Tracking Number:	*GHPI-125840691*	*State:*	*Arkansas*
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Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Rosalind Minor	01/16/2009	01/16/2009
Approved-Closed	Rosalind Minor	10/07/2008	10/07/2008

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Rosalind Minor	01/13/2009	01/13/2009	Anita Carter	01/15/2009	01/15/2009

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Filing Fee	Note To Filer	Rosalind Minor	10/02/2008	10/02/2008

SERFF Tracking Number:	*GHPI-125840691*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Company*	*State Tracking Number:*	*40412*
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Product Name:	*AR Individual PPO*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 10/07/2008
Implementation Date:
Status: Approved
Comment: We re-opened this file in order to discuss and review additional information on the trend increases mentioned in the actuarial memorandum.

We have reviewed the additional information that was provided by Mr. Jim Paprocki and accept the trend increases as explained.

This submission will keep its original approval date of 10/7/08.

Rate data does NOT apply to filing.

SERFF Tracking Number:	*GHPI-125840691*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Company*	*State Tracking Number:*	*40412*
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Product Name:	*AR Individual PPO*		
Project Name/Number:	*/*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form	PPO Certificate of Coverage	Approved-Closed	Yes
Form	Supplemental Rider for Mental Health Benefits	Approved-Closed	Yes
Form	Prescription Drug Rider	Approved-Closed	Yes
Form	Schedule of Benefits	Approved-Closed	Yes
Form	Supplemental Rider for Temporomandibular Joint DisorderTreatment	Approved-Closed	Yes
Form	Application/Health Statement Form	Approved-Closed	Yes

SERFF Tracking Number:	*GHPI-125840691*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Company*	*State Tracking Number:*	*40412*
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Product Name:	*AR Individual PPO*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 10/07/2008
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*GHPI-125840691*	*State:*	*Arkansas*
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Form	Application/Health Statement Form	Approved-Closed	Yes

SERFF Tracking Number:	*GHPI-125840691*	*State:*	*Arkansas*
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Project Name/Number:	*/*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	01/13/2009
Submitted Date	01/13/2009
Respond By Date	

Dear Anita Carter,

This will acknowledge receipt of the captioned filing.

Objection 1

- Health - Actuarial Justification (Supporting Document)

Comment: I am reopening this filing because I noticed that the actuarial memorandum refers to trend increases. Our Department does not allow trend increase. Our rate increases are based on the actual experience of the block of business.

Please advise if the trend increases addressed in the actuarial memorandum are automatically applied quarterly. If so, we will have to withdraw our approval of the rates since we do not allow trend increases and a new actuarial memorandum must be submitted removing the language on trend increases.

If you wish to discuss this matter, you may call me at (501)371-2767.

Please feel free to contact me if you have questions.
Sincerely,
Rosalind Minor

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	01/15/2009
Submitted Date	01/15/2009

Dear Rosalind Minor,

Comments:

SERFF Tracking Number:	*GHPI-125840691*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Company*	*State Tracking Number:*	*40412*
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Response 1

Comments: Rosalind:
See below for Jim Paprocki's response per our conversation yesterday.
Anita

I believe that there is a misinterpretation of how we apply trend to our rates. Our intent is not to alter the rates on existing policyholders on a quarterly basis, but rather to adjust our new business rates quarterly, thus reflecting the ever-increasing cost to provide medical coverage.

We administer our individual policies on the basis of each member maintaining an anniversary month that corresponds with the date of the original sale. When a member purchases a policy at a given rate, that rate will be effective for 12 months, until the member's policy anniversary in the following year. Each quarter we would like to increase our new business rate so that new members written in subsequent calendar quarters will receive rates that better reflect the medical costs that will be incurred in that latter 12-month period. The rates of the members written in the previous quarters remain unchanged until those members reach their 12-month anniversary date. At renewal, members will receive rates that are the same as the new business rates for that quarter.

The following example describes our position more explicitly. In this example, we assume that annual trend is 12.55% and therefore the trend for one quarter is 3.00%.

Effective Date Trend Increase Rate
2009Q1 Filed Rate Schedule $100.00
2009Q2 3.0% $103.00
2009Q3 3.0% $106.09
2009Q4 3.0% $109.27
2010Q1 3.0% $112.55

Member A purchases a policy in January 2009 and receives a rate of $100/month, and that rate is applicable for 12 months until January 2010.
Member B (with the same demographic profile) purchases the same policy in April 2009 and receives a rate of $103.00/month, and that rate is applicable for 12 months until April 2010.
Member C (also with the same demographic profile) purchases the same policy in January 2010 and receives a rate of $112.55/month. Member A, who is renewing in January 2010, also receives a rate of $112.55/month. Renewal rates are always equal the new business rates. Both of these rates are applicable until January 2011.

Additionally, the rate filing that was submitted on 01/08/2009 was for a policy form that has not yet been approved for

use in Arkansas. Therefore, we withdraw the 01/08/2009 rate filing at this time. We will resubmit the rate filing along with the policy form.

I hope that the above explanation more clearly explains our position and is acceptable to the Arkansas Insurance Department. Please let me know if you have any questions or would like to discuss further.

Jim Paprocki
Director, Actuarial Services
Coventry Health Care
(314) 506-1526
jpaprocki@cvty.com

Related Objection 1

Applies To:

- Health - Actuarial Justification (Supporting Document)

Comment:

I am reopening this filing because I noticed that the actuarial memorandum refers to trend increases.
Our Department does not allow trend increase. Our rate increases are based on the actual experience of the block of business.

Please advise if the trend increases addressed in the actuarial memorandum are automatically applied quarterly. If so, we will have to withdraw our approval of the rates since we do not allow trend increases and a new actuarial memorandum must be submitted removing the language on trend increases.

If you wish to discuss this matter, you may call me at (501)371-2767.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Sincerely,
Anita Carter, Geneva Clark

SERFF Tracking Number:	*GHPI-125840691*	*State:*	*Arkansas*
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Product Name:	*AR Individual PPO*		
Project Name/Number:	*/*		

Note To Filer

Created By:

Rosalind Minor on 10/02/2008 02:52 PM

Subject:

Filing Fee

Comments:

Before we review this submission, it is requested that you submit a filing fee in the amount of $120.00

SERFF Tracking Number:	*GHPI-125840691*	*State:*	*Arkansas*
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Project Name/Number:	*/*		

Form Schedule

Lead Form Number:

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	AR_PPOCOCIND_08_CHL	Certificate	PPO Certificate of Coverage	Initial			AR_PPOCOCIND_08_CHL.pdf
Approved-Closed	AR_MHIND_08_CHL	Certificate Amendment, Insert Page, Endorsement or Rider	Supplemental Rider for Mental Health Benefits	Initial			AR_MHIND_08_CHL.pdf
Approved-Closed	AR_RX08IND_CHL	Certificate Amendment, Insert Page, Endorsement or Rider	Prescription Drug Rider	Initial			AR_RX08IND_CHL.pdf
Approved-Closed	AR_SOBIND_08_CHL	Schedule Pages	Schedule of Benefits	Initial			AR_SOBIND_08_CHL.pdf
Approved-Closed	AR_TMJ_08_CHL	Certificate Amendment, Insert Page, Endorsement or Rider	Supplemental Rider for Temporomandibular Joint DisorderTreatment	Initial			AR_TMJ_08_CHL.pdf
Approved-Closed	CHAR 00007	Application/ Enrollment Form	Application/Health Statement Form	Initial			CHAR 00007.pdf

Coventry*One*

Individual Benefits

2008

PREFERRED PROVIDER ORGANIZATION ("PPO")

Comprehensive Health Expense Coverage

CERTIFICATE OF COVERAGE

NOTICE

THIS CERTIFICATE AND ALL ATTACHED RIDERS SHOULD BE READ AND RE-READ IN THEIR ENTIRETY

Benefits underwritten and administered by Coventry Health and Life Insurance Company.

THIS HEALTH PLAN HAS AN OUT-OF-NETWORK OPTION WHICH GIVES YOU THE OPPORTUNITY TO SEEK CARE FROM NON-PARTICIPATING PROVIDERS. UTILIZING THE OUT-OF-NETWORK OPTION WILL INCREASE THE AMOUNT YOU PAY FOR THE CARE YOU RECEIVE. PLEASE READ THE PROVISION ENTITLED "COPAYMENTS, COINSURANCE, AND DEDUCTIBLES" WHICH APPEARS AS SECTION 2.6 BELOW AND CALL OUR MEMBER SERVICES DEPARTMENT WITH QUESTIONS.

Please consult Your Member materials and Provider Directory for more details. If you have any additional questions, please write or call us at:

Attn: Coventry*One* Customer Service
Coventry Health & Life
5350 Poplar Ave. Suite 390
Memphis, TN 38119

(866-364-5663)

SCHEDULE OF IMPORTANT TELEPHONE NUMBERS AND ADDRESSES

Coventry Health and Life Insurance Co. Coventry*One* Member Services 5350 Poplar Avenue, Ste 390 Memphis, Tennessee 38119 (866) 364-5663 (866) 765-7659 TDD	Coventry Health and Life Insurance Co. Medical Management 14955 Heathrow Forest Parkway Houston, Texas 77032 (800) 292-4470
Coventry Health and Life Insurance Co. Physician/Ancillary/Facility Claims Department P.O. Box 7170 London, Kentucky 40742 (866) 765-7747	Coventry Behavioral Health Line 5350 Poplar Avenue, Ste 390 Memphis, Tennessee 38119 (877) 765-865-2566 (866) 765-7659 TDD
Coventry Health and Life Insurance Co. Member Appeals 3200 Highland Avenue Downers Grove, Illinois 60515 (866) 765-7747 (866) 765-7659 TDD	Arkansas Insurance Department Consumer Services Division 1200 West Third Street Little Rock, Arkansas 72201-1904 (800) 852-5494 insurance.consumers@arkansas.gov

Table of Contents

Coventry Health and Life Insurance Company (CHL)

Certificate of Coverage

The Agreement between Coventry Health and Life Insurance Company. as the underwriter administrator (hereafter called "the Plan") and You and between the Plan and Your Dependents as Members of the Plan is made up of:

- This Certificate of Coverage (COC) and Amendments;
- The Application/Change Form;
- Applicable Riders;
- Schedule of Benefits.

No person or entity has any authority to waive any Agreement provision or to make any changes or Amendments to this Agreement unless approved in writing by an Officer of the Plan, and the resulting waiver, change, or Amendment is attached to the Agreement. This Agreement begins on the date defined upon the acceptance of Your Application. It continues, until replaced or terminated, while its conditions are met. You are subject to all terms, conditions, limitations, and exclusions in this Agreement and to all the requirements and regulations of the Plan. By paying Premiums or having Premiums paid on Your behalf, You accept the provisions of this Agreement.

THIS AGREEMENT SHOULD BE READ AND RE-READ IN ITS ENTIRETY. Many of the provisions of this Agreement are interrelated; therefore, reading just one or two provisions may give You a misleading impression. Many words used in this Agreement have special meanings. These words will appear capitalized and are defined for You. By using these definitions, You will have a clearer understanding of Your coverage.

From time to time, any of the above documents may be amended. When that occurs, the Plan may provide a revision to You for this Agreement. You should keep this document in a safe place for Your future reference.

The Plan is responsible for making benefit determinations in accordance with the Individual Certificate of Coverage and the Plan's Agreements with Participating Providers. The Plan does not and will not make medical treatment decisions. Only Providers may make such decisions after meeting with You. If the Plan denies a claim or Authorization for payment of a recommended service, the treating Provider may request reconsideration of that decision through the Plan's Provider dispute resolution procedure. Regardless of whether the Provider requests reconsideration of the decision through the dispute resolution procedure, You may request reconsideration of that decision through the Member Complaint and Grievance Procedure described in Section 10 of this Certificate of Coverage. The Plan's Provider dispute resolution procedure and the Member Complaint and Grievance Procedure are separate and independent of each other.

RIGHT TO EXAMINE THE CONTRACT

You have the right to review this Certificate of Coverage for ten (10) days. If You decide that You do not want coverage under the Contract, return the Certificate of Coverage to

Us, Attention: Coventry*One*[SM] Enrollment, 5350 Poplar Ave, Suite 390, Memphis, Tennessee 38119. By returning this Certificate of Coverage to the Plan within ten (10) days from the date of its receipt by You, the Contract will be void and all premiums paid for Your Coverage under the Contract will be refunded to You. If You do not return this Certificate of Coverage to the Plan within ten (10) days from the date of its receipt by You, the Contract will be in force as of the Effective Date and You will be required to pay applicable premiums for continued coverage.

SECTION 1
DEFINITIONS

Any capitalized terms listed in this Section shall have the meaning set forth below whenever the capitalized term is used in this Agreement.

1.1 "Abortion"

The termination of pregnancy.

- **Medically Necessary Abortion**

  The termination of pregnancy when the pregnancy jeopardizes the mothers' life or if the fetus is diagnosed to have congenital anomalies incompatible with life.

- **Elective Abortion**

  The voluntary termination of pregnancy for other than medical reasons as described in Medically Necessary Abortion.

1.2 "Acute"

Refers to an Illness or Injury that is both severe and of recent onset.

1.3 "Administrative Appeal"

An Appeal of a decision that has not been issued for medical necessity or medical appropriateness, and is administrative in nature. Examples of Administrative Appeal include, but are not limited to Deductibles, Copayments, or a specifically excluded benefit, such as acupuncture.

1.4 "Adverse Benefit Determination"

A determination that an admission, availability of care, continued stay or other health care service has been reviewed and, based upon the information provided, does not meet the requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the payment for the requested service is therefore denied, reduced or terminated.

An Adverse Benefit Determination based in whole or in part on a medical judgment includes:

- The failure to cover services because they are determined to be Experimental or Investigational;
- The failure to cover services because they are determined to be not Medically Necessary or inappropriate;
- The failure to cover services because they are Cosmetic;
- The failure, reduction, or termination regarding the availability, delivery or quality of health care services;

- The failure, reduction, or termination regarding claims payment, handling or reimbursement for health care services; and
- The failure, reduction, or termination regarding terms of the contractual relationship between a Member and the Plan.

1.5 "Agreement"

Refers to this COC, any individual Application/Change Forms, Amendments, Schedules, and Riders, and other documents which constitute the agreement regarding the benefits, exclusions and other conditions between the Plan and the Member.

1.6 "Alternate Facility"

A non-Hospital health care facility or an attached facility designated as such by a Hospital which provides one or more of the following services on an outpatient basis pursuant to the law of the jurisdiction in which treatment is received, including without limitation:

- Scheduled surgical services;
- Emergency Health Services;
- Urgent Care Services, or prescheduled rehabilitative services;
- Laboratory or diagnostic services;
- Inpatient or outpatient Mental Health Services or Substance Abuse Services.

1.7 "Alternate Recipient"

The child or children identified in the medical child support order as being eligible to receive health care Coverage pursuant to the medical child support order.

1.8 "Amendment"

Any attached written description of additional or alternative provisions to the Agreement and/or this COC. Amendments are effective only when Authorized in writing by the Plan and are subject to all conditions, limitations and exclusions of the Agreement except for those which are specifically amended.

1.9 "Ancillary Service"

Those services not performed by an MD or DO and usually associated with, but not limited to lab, x-ray, nursing, dietary, pharmacy, and rehabilitative services.

1.10 "Appeal"

An Appeal is a request by You or Your Authorized Representative for consideration of an Adverse Benefit Determination of a Health Service request or benefit that You believe You are entitled to receive.

1.11 "Application/Change Form"

The application and medical questionnaire required for enrollment under the Contract.

1.12 "Authorization/Prior Authorization"

Approval for payment for certain services to be performed as given by the Plan. Authorization does not guarantee payment if You are not eligible for Covered Services at the time the service is provided.

1.13 "Authorized Representative"

An Authorized Representative is an individual authorized by You or state law to act on Your behalf in obtaining claim payment or during the Appeal process. A Provider may act on Your behalf with Your expressed consent, or without Your expressed consent in emergent situations. For Appeals, Your Authorized Representative must have an Authorization for Disclosure of Personal Health Information to Appeals Representative form signed by You. Call the Member Services Department to obtain this form or visit the website listed on Your Schedule of Important Numbers and Addresses to obtain this form.

1.14 "Basic Health Services"

Health Services which a Member may reasonably require in order to be maintained in good health, including as a minimum, inpatient Hospital, Physician, outpatient services, and Emergency Health Services that are covered under this COC. Benefits provided by Riders attached to this COC are not considered Basic Health Services for the purpose of this definition.

1.15 "Chemical Dependency"

The psychological or physiological dependence upon and abuse of drugs, including alcohol, characterized by drug tolerance or withdrawal and impairment of social or occupational role functioning or both.

1.16 "Chiropractic Services"

Services that are Medically Necessary, clinically appropriate and rendered by a chiropractor working within the chiropractor's lawful scope of practice.

1.17 "Chronic Medical Condition"

A health condition that is continuous or persistent over an extended period of time (greater than 6 months) that;

- Requires periodic visits with a health care provider, and
- May be associated with episodic rather than continuous periods of incapacity.

1.18 "Coinsurance"

The percentage amount You must pay in relation to a specified benefit and is payable as a condition of the receipt of certain services as provided in this COC. The out of network Coinsurance is a standard percentage, as referenced in Your Schedule of Benefits, plus the difference between the Plan's Out of Network Rate and the Provider's billed amount.

1.19 "Complaint"

Any expression of dissatisfaction expressed by You or Your Authorized Representative regarding a Health Plan issue. A verbal Complaint is informational in nature and cannot be Appealed (e.g., a Complaint concerning long wait times at a Physician's office). A written Complaint is considered to be a Grievance.

1.20 "Confinement" and "Confined"

An uninterrupted stay of at least twenty-four (24) hours following formal admission to a Hospital, an Alternate Facility or SNF. One period of confinement means consecutive days of in-hospital service received as an in-patient, or successive confinements when discharge from and readmission to the hospital occurs within a period of time not more than ninety (90) days.

1.21 "Contract Year"

The period during which the total amount of yearly benefits under Your Coverage is calculated. The Contract Year is the period of twelve (12) consecutive months commencing on the Subscriber Effective Date and each subsequent anniversary.

1.22 "Copayment"

A specified dollar amount You must pay as a condition of the receipt of certain services as provided in this COC. There may be more than one Copayment charged by the same Provider on the same day.

1.23 "Cosmetic Services and Surgery"

Plastic or Reconstructive Surgery: (i) from which no significant improvements in physiologic function could be reasonably expected; or (ii) that does not meaningfully restore the proper function of the body or treat Illness or disease; or (iii) done primarily to improve the appearance or diminish an undesired appearance of any portion of the body.

1.24 "Coventry Transplant Network Facility"

A Hospital, appointed as a Coventry Transplant Network Facility by the Plan, that has contracted with the Coventry Transplant Network, or its successor, to render Medically Necessary and medically appropriate Health Services for Covered transplants. A Coventry Transplant Network Facility may or may not be located within the Plan's Service Area. You may request a listing, that may be amended

from time to time, of Coventry Transplant Network Facilities from the Member Services Department listed in the Schedule of Important Numbers.

1.25 "Coverage" or "Covered"

The COC provides for two benefit levels: an In-Network benefit level for Health Services obtained through Participating Providers and an Out-of-Network level for Health Services rendered by Providers outside the Plan's network. You have the flexibility of deciding which Coverage level You wish to access at the time You obtain medical care. If You follow the requirements outlined in Section 6 and stay within the Plan's network of Participating Providers, services will be Covered at the In-Network benefit level. Services from Non-Participating Providers will be Covered at the lower Out-of-Network benefit level. The In-Network and Out-of-Network benefits are described in the Schedule of Benefits attached to this COC. The entitlement by a Member to Covered Services under the COC, subject to the terms, conditions, limitations and exclusions of the COC, including the following conditions: (a) Health Services which must be provided when the COC is in effect; and (b) Health Services which must be provided prior to the date that any of the termination conditions listed under Section 5 of this COC occur; and (c) Health Services which must be provided only when the recipient is a Member and meets all eligibility requirements specified in the COC; and (d) Health Services which are Medically Necessary.

1.26 "Covered Services"

The services or supplies provided to You for which the Plan will make payment, as described in the Agreement.

1.27 "Custodial Care"

Care is considered custodial when it is primarily for the purpose of helping the Member with activities of daily living or meeting personal needs and can be provided safely and reasonably by people without professional skills or training. This term includes such other care that is provided to an individual who, in the opinion of the Medical Director, has reached his or her maximum level of recovery. This term also includes services to an institutionalized person, who cannot reasonably be expected to live outside of an institution. Examples of Custodial Care include rest cures, respite care and home care which is or which could be provided by family members or private duty caregivers.

1.28 "Deductible"

The dollar amount of medical expenses for Covered Services that You are responsible for paying in a Contract Year before benefits subject to the Deductible are payable under this Agreement. The annual Deductible need only be met once per Contract Year. If You consult an Out of Network Provider, the difference between the Plan Out of Network Rate and the Provider's billed charges does not apply to the Deductible.

1.29 "Dependent"

Any member of a Subscriber's family who meets the eligibility requirements and who is properly enrolled for Coverage under the Agreement and whose Premiums are paid .

1.30 "Detoxification"

Hospital inpatient medical care to ameliorate acute medical conditions associated with Chemical Dependency.

1.31 "Directory of Health Care Providers" ("Provider Directory")

A listing of Participating Providers. Please be aware the information in the directory is subject to change. The list of Participating Providers is available on the website or upon request. You will be provided with an updated directory at least once each calendar year/Contract Year showing addition and deletions.

1.32 "Durable Medical Equipment"

Medical equipment Covered under this COC, which can withstand repeated use and is not disposable, is used to serve a medical purpose, is generally not useful to a person in the absence of an Illness or Injury, and is appropriate for use in the home. Medically Necessary, non-disposable accessories that are commonly associated with the use of a Covered piece of Durable Medical Equipment will be considered Durable Medical Equipment.

1.33 "Effective Date"

The date of Coverage as determined by the Plan with the acceptance of Medical Underwriting and agreed to by the Subscriber.

1.34 "Eligible Expenses"

Charges for Covered Health Services, incurred while the Agreement is in effect.

1.35 "Emergency" and "Medical Emergency"

A medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that would lead a prudent layperson, possessing an average knowledge of health and medicine, to believe that immediate medical care is required, which may include, but shall not be limited to:

- Placing the person's health in significant jeopardy;
- Serious impairment to a bodily function;
- Serious dysfunction of any bodily organ or part;
- Inadequately controlled pain; or
- With respect to a pregnant woman who is having contractions:

- There is inadequate time to effect a safe transfer to another Hospital before delivery; or
- That the transfer to another Hospital may pose a threat to the health or safety of the woman or unborn child.

Some examples of an Emergency medical condition include but are not limited to:

- Broken bone;
- Chest pain;
- Seizures or convulsions;
- Severe or unusual bleeding;
- Severe burns;
- Suspected poisoning;
- Trouble breathing;
- Vaginal bleeding during pregnancy.

Generally, Eligible Expenses for Emergency Health Services are the charges for the Health Services and items furnished in a Hospital which are required to determine, evaluate and/or treat during the course of the Emergency and when Medically Necessary for stabilization and initiation of treatment. The Emergency Health Services must be provided by or under the direction of a Physician, and are subject to the exclusions and other provisions set out in this COC. The Member will be assessed the same Copayment whether the Emergency Health Services are rendered by a Participating or Non-Participating Provider. (Refer to the Schedule of Benefits in the back of the COC). **EMERGENCY HEALTH SERVICES RECEIVED WHILE YOU ARE OUTSIDE OF THE SERVICE AREA ARE COVERED WHEN THE REQUIREMENTS EXPLAINED IN SECTION 7 OF THIS COC ARE FOLLOWED. IF MEDICALLY NECESSARY FOLLOW-UP CARE RELATED TO THE INITIAL MEDICAL EMERGENCY IS REQUIRED, YOU MUST OBTAIN PRIOR ATHORIZATION TO BE ELIGIBLE FOR THE IN-NETWORK LEVEL OF BENEFITS.**

When an Emergency occurs, a Member should seek medical attention immediately from a Hospital, Physician's office or other Emergency facility. If the Member is unable to indicate a choice of Hospital, or if travel to the nearest Participating Hospital would endanger the Member, the Member should receive medical attention from the Hospital to which he or she is taken, and must notify the Plan within forty-eight (48) hours of the onset of the Emergency, or within a reasonable period as dictated by the circumstances. At the request of the Plan, You must make available full details of the Emergency Health Services received.

1.36 "Experimental or Investigational"

A health product or service is deemed Experimental or Investigational if one or more of the following conditions are met:

- Any drug not approved for use by the FDA; any drug that is classified as IND (investigational new drug) by the FDA;
- Any health product or service that is subject to Investigational Review Board (IRB) review or approval;
- Any health product or service whose effectiveness is unproven based on clinical evidence reported in Peer-Reviewed Medical Literature.

1.37 "Full-time Student"

An eligible Dependent is enrolled in and attending, full-time, a recognized course of study or training at:

(a) An accredited high school or vocational school; or

(b) An accredited college or university; or

(c) A licensed technical school, beautician school, automotive school, or similar training school.

1.38 "Genomics"

Genomic based therapeutics are drugs that are the products of gene technology and the molecular basis of disease associated with biological targets (e.g. monoclonal antibodies).

1.39 "Grievance"

A written Complaint submitted by or on behalf of an enrollee regarding the:

(a) Availability, delivery or quality of health care services, including a Complaint regarding an adverse determination made pursuant to utilization review; or

(b) Claims payment, handling or reimbursement for health care services; or

(c) Matters pertaining to the contractual relationship between an enrollee and a health carrier.

Depending on the nature of Your Grievance, the Plan will handle Your Grievance as a Complaint, Pre-Service Appeal, Post-Service Appeal, or Urgent Care Appeal. See Section 10, Resolving Complaints and Grievances, for additional information.

1.40 "Health Services"

The health care services and supplies Covered under the Agreement, except to the extent that such health care services and supplies are limited or excluded under the Agreement.

1.41 "Home Health Agency"

A program which is engaged in providing Home Health Services, is properly licensed or otherwise qualified and authorized pursuant to the law of the jurisdiction in which treatment is received, and is Medicare certified.

1.42 "Home Health Care Services"

Those services, determined by the Plan to be Medically Necessary, which would be Covered if provided in an acute care or SNF setting. They must be part of a treatment plan, ordered by the Member's Physician and Authorized by the Plan. They must be provided by appropriately licensed Providers. The services include, but are not limited to, physical therapy, speech therapy and occupational therapy and other skilled nursing services.

1.43 "Hospital"

An institution, operated pursuant to law, which: (a) is primarily engaged in providing Health Services on an inpatient basis for the care and treatment of injured or sick individuals through medical, diagnostic and surgical facilities by or under the supervision of one or more Physicians; (b) has twenty-four (24) hour nursing services by or under the supervision of registered graduate professional nurses (RNs); and (c) is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Hospital Association, or certified under Title XVIII of the Social Security Act (the Medicare program. A facility that is primarily a place for rest, Custodial Care, or educational or rehabilitative care or care of the aged, drug addicts or alcoholics, a nursing home, convalescent home, or similar institution is not a Hospital.

1.44 "Illness"

Physical ailment, disease, or pregnancy. For the purpose of this definition, the term Illness does not apply to Mental Illness or Substance Abuse.

1.45 "Infertility"

Infertility means the inability of a woman to conceive a pregnancy after twelve (12) months of unprotected sexual intercourse between a male and a female, or the inability of a woman to carry a pregnancy to live birth as evidenced by three consecutive miscarriages (spontaneous abortions).

1.46 "Infertility Services"

Those Health Services designed for the primary purpose of successfully fostering and achieving conception and pregnancy.

1.47 "Injectables"

Prescription medications injected by or under the direct supervision of a physician. Self-injectables are medications that are injected by the patient.

1.48 "Injury"

Bodily damage other than Illness including all related conditions and recurrent symptoms.

1.49 "Inquiry"

Any question from You or Your Authorized Representative that is not a Pre-Service Appeal, a Post-Service Appeal or an Urgent Care Appeal, or Complaint.

An example of an Inquiry would be benefit questions, claims status, or a change of personal demographic information.

1.50 "Intensive Care Unit (ICU)"

That part of a Hospital specifically designed as an Intensive Care Unit permanently equipped and staffed to provide more extensive care for critically ill or injured patients than available in other hospital rooms or wards. Care includes close observation by trained and qualified personnel whose duties are primarily confined to the ICU.

1.51 "Investigational Review Board (IRB)"

A university or Participating Hospital panel composed of faculty and researchers that determines whether a procedure will be rejected as experimental and investigational or approved as medically appropriate.

1.52 "Late Enrollees"

Shall mean individuals who fail to enroll with the Plan for Coverage under the Agreement during the required thirty-one (31) day period when they first become eligible for Coverage. This term does not include special enrollees.

1.53 "Lifetime"

Lifetime refers to the natural life of the member.

1.54 "Maintenance Therapy"

Rehabilitative services and associated expenses designed primarily to be long-term, with no significant medical improvement to the patient being reasonably expected as determined by the Your Physician or Medical Director.

1.55 "Maternity Services"

Includes prenatal and postnatal care, childbirth, and any complications associated with pregnancy.

1.56 "Medical Director"

The Physician specified by the Plan as the Medical Director or other Plan staff designated to act for, under the general guidance of, and in consultation with the Medical Director.

1.57 "Medically Necessary"

Medically Necessary means those services, supplies, equipment and facility charges that are not expressly excluded under this Agreement and are:

- Medically appropriate, so that expected health benefits (such as, but not limited to, increased life expectancy, improved functional capacity, prevention of complications, relief of pain) materially exceed the expected health risks;

- Necessary to meet Your health needs, improve physiological function and required for a reason other than improving appearance;

- Rendered in the most cost-efficient manner and setting appropriate for the delivery of the Health Service;

- Consistent in type, frequency and duration of treatment with scientifically-based guidelines of national medical research, professional medical specialty organizations or governmental agencies that are generally accepted as national authorities on the services, supplies, equipment or facilities for which coverage is requested;

- Consistent with the diagnosis of the condition at issue;

- Required for reasons other than Your comfort or the comfort and convenience of Your Physician; and

- Not Experimental or Investigational as determined by the Plan under the Plan's Experimental Procedures Determination Policy.

1.58 "Medical Necessity Appeal"

An Appeal of a determination by the Plan or its designed utilization review organization that is based in whole or in part on a medical judgment that includes an admission, availability of care, continued stay or other service which has been reviewed and, based on the information provided, does not meet the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness and payment for the service is denied, reduced or terminated.

1.59 "Medicare"

Part A, B and D of the insurance program established by the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

1.60 "Member"

Any Subscriber or Dependent or Qualified Beneficiary who enrolled for Coverage under this Agreement in accordance with its terms and conditions.

1.61 "Member Advisory Committee"

The Committee which the Plan has organized to permit Members to make suggestions about the policies and operations of the Plan.

1.62 "Member Effective Date"

The date the Plan's Medical Underwriting presents to the applicant that coverage will begin, in accordance with the terms of this Agreement, which Coverage shall begin at 12:01 a.m. on such date.

1.63 "Mental Health and Substance Abuse Designee"

The organization, entity or individual that provides or arranges Covered Mental Health and Substance Abuse Services under contract to the Plan.

1.64 "Mental Health Condition(s)"

Any condition or disorder defined by categories listed in the most recent edition of the International Classification of Diseases Manual and the Diagnostic and Statistical Manual of Mental Disorders except for Chemical Dependency.

1.65 "Nanometrics"

Nanometric based therapeutics are products that use ultra-small (nanometric/molecular-sized) electronic or mechanical devices.

1.66 "Non-Participating Provider"

A Provider who has no direct or indirect written agreement with the Plan to provide Health Services to Members.

1.67 "Officer"

The person holding the office of President and/or CEO or his or her designee.

1.68 "Orthotic Appliances and Prosthetic Devices"

Orthotic Appliances correct a defect of a body form or function, whereas Prosthetic Devices aid body functioning or replace a limb or body part.

1.69 "Out-of-Network Rate (ONR)"

In most cases, the Out-of-Network Rate (ONR) is equivalent to the current Medicare fee schedule for the services and supplies rendered. In all other cases, the Out-of-Network Rate will be determined by the Plan. Please feel free to contact the Plan regarding the Out-of-Network Rate in such cases.

1.70 "Partial Hospitalization"

Physician directed intensive or intermediate treatment for less than twenty-four (24) hours, but more than four (4) hours in a day, in a licensed or certified facility or program.

1.71 "Participating Provider"

A Provider who has entered into a direct or indirect written agreement with the Plan to provide Health Services to Members. The participation status of Providers may change from time to time.

1.72 "Peer-Reviewed Medical Literature"

A scientific study which has been published in the English language (mostly

American) medical literature only after review by academic experts for structure of study and validity of conclusions, prior to acceptance for publication. Peer-Reviewed Medical Literature does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company, a device manufacturing company, or health vendor.

1.73 "Physician"

Any Doctor of Medicine, "M.D.", or Doctor of Osteopathy, "D.O.", who is duly licensed and qualified under the law of the jurisdiction in which treatment is received working within the scope of his/her licensed authority.

1.74 "Plan"

Coventry Health and Life Insurance Company.

1.75 "Post-Service Appeal"

An appeal for which an Adverse Benefit Determination has been rendered for a service that has already been provided.

1.76 "Pre-Existing Medical Conditions"

A limitation or exclusion of benefits relating to any medical condition for which medical advice, diagnosis, care or treatment was recommended by, or received from, a licensed Provider within the six (6)months immediately preceding the Member's Effective Date under the Agreement and extending for a period of not more than twelve (12) months after the Effective Date or as to pregnancy existing on the effective date of Coverage. Genetic information shall not be treated as a preexisting condition in the absence of a diagnosis of the condition related to such information.

1.77 "Pre-Service Appeal"

An appeal for which an Adverse Benefit Determination has been rendered for a service that has not yet been provided and requires Prior Authorization.

1.78 "Premium"

The monthly fee required from each Member in accordance with the terms of the Agreement.

1.79 "Preventive Care Services"

Medical services (as defined by the Plan) provided to prevent or arrest the further manifestation of human illness or injury. These services include, but may not be limited to:

- Periodic health evaluations, including tests and diagnostic procedures in connection with routine examinations;
- Routine prenatal care;
- Well-child care; and
- Adult and child immunizations.

Preventive Care Services does not include any service or benefit intended to treat an existing illness, injury, or condition.

1.80 "Provider/Provider Network"

A Physician, Hospital, SNF, Home Health Agency, hospice, pharmacy, podiatrist, optometrist, chiropractor or other health care institution or practitioner, licensed, certified or otherwise authorized pursuant to the law of the jurisdiction in which care or treatment is received. Health care practitioners must be working within the scope of their license/practice.

1.81 "Qualified High Deductible Health Plan ("QHDHP")"

A health plan with Deductible and out-of-pocket limits for individuals and families that meets requirements under section 223 of the Internal Revenue Code. The limits will be found in Your Schedule of Benefits (SOB).

1.82 "Qualified Medical Child Support Order" ("QMCSO")

A medical child support order, issued by a court of competent jurisdiction or through an administrative process established under state law, which creates or recognizes the existence of an Alternate Recipient's right to receive benefits for which a Member is eligible under the Agreement in accordance with applicable state and federal laws.

A "Medical Child Support Order" is any judgment, decree, or order (including approval of a settlement agreement) which: (1) provides for child support with respect to a Member's child under the Agreement or provides for health benefit coverage to such child, is made pursuant to a State domestic relations law (including community property law), and relates to benefits under the Benefits Agreement; or (2) is made pursuant to a law relating to medical child support described in Section 1908 of the Social Security Act.

Contact Member Services if You would like to see a complete copy of the procedures for determining whether an order constitutes a QMCSO.

1.83 "Reconstructive Surgery"

Surgery which is incidental to an Injury, Illness or congenital anomaly when the primary purpose is to restore normal physiological functioning of the involved part of the body. (A congenital anomaly is a defective development or formation of a part of the body, when such defect is determined by the treating Physician to have been present at the time of birth.) For the purpose of Coverage under the Plan, Reconstructive Surgery on the opposite breast to restore symmetry, including Prosthetic Devices/implants or reduction mammoplasty, is included in this definition.

1.84 "Rider"

Any description of additional Covered Health Services attached to the Agreement.

Health Services provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when issued by the Plan and are subject to all conditions, limitations and exclusions of the Agreement except for those that are specifically amended.

1.85 "Schedule of Covered Services"

Description of Covered Services contained in the chart in Section 6.

1.86 "Semi-private Accommodations"

A room with two (2) or more beds in a Hospital. The difference in cost between Semi-private Accommodations and private accommodations is Covered only when private accommodations are Medically Necessary or when Semi-private Accommodations are not available and when an exception has been made by the Medical Director in advance of the admission. Exceptions may or may not be granted by the Plan.

1.87 "Service Area"

The geographic area served by the Plan.

1.88 "Skilled Nursing Facility (SNF)"

A facility which operates pursuant to the law, provides inpatient skilled nursing care under the supervision of a duly licensed physician, rehabilitation services or other related Health Services; and is certified by Medicare. The term "Skilled Nursing Facility" does not include a convalescent nursing home, rest facility, or facility for the aged which furnishes primarily Custodial Care, including training in activities of daily living or for the care of drug addicts or alcoholics or a facility primarily used for the care and treatment of mental diseases or disorders, or custodial or educational care.

1.89 "Specialty Care Physician/Specialist"

A Physician who provides medical services to Members within the range of a medical specialty.

1.90 "Subscriber"

An applicant who has elected the Plan's Coverage for himself and any eligible Dependents through submission of an Application/Change Form and for whom, Premiums have been received by the Plan.

1.91 "Total Disability"

Complete inability of the Member to perform all of the substantial and material duties of his or her regular gainful occupation, or complete inability of the Member to engage in gainful employment or occupation for which he or she is or becomes qualified by reason of education, training, or experience. For an unemployed Dependent, Total Disability means complete inability of the Member to engage in most of the normal activities of a person of like age and gender. The

disability, for Subscriber or Dependent, must require regular care and attendance by a Physician who is someone other than an immediate family member.

1.92 "Urgent Care Appeal"

An Appeal that must be reviewed under an expedited Appeal process because the application of non-Urgent Care Appeal time frames could seriously jeopardize:

- The life or health of the Member; or
- The Member's ability to regain maximum function.

An Urgent Care Appeal also is an Appeal involving:

- Care that the treating Physician deems urgent in nature; or
- The treating Physician determines that a delay in the care would subject the Member to severe pain that could not be adequately managed without the care or treatment that is being requested.

1.93 "Urgent Care Services"

A condition that requires care which is an unexpected Illness or Injury that requires prompt medical attention. Examples of Urgent Care conditions include fractures, lacerations or severe abdominal pain. These conditions may also constitute Emergencies in those situations that would lead a prudent layperson, possessing an average knowledge of health and medicine, to believe immediate medical care is required.

Urgent Care Services received while You are outside of the Service Area are Covered when the requirements explained Section 7 of this COC are followed. If these requirements are not followed Medically Necessary Urgent Care Services will be Covered at the lower Out-of-Network level of benefits.

If possible, contact Your Physician prior to receiving services to ensure that the Urgent Care Services will be Covered. However, failure to notify Your Physician will not result in denial of Coverage. The records of Your Urgent Care visit will be reviewed against the criteria as defined in Section 1.35 of this COC. If Medically Necessary follow-up care related to the initial Urgent Care Service is required, please contact Your Physician to be eligible for the In-Network level of benefits.

If a condition requiring Urgent Care develops, a Member may go to the nearest Urgent Care center or Physician's office. The Plan will provide Coverage at the In-Network benefit level for a condition requiring urgent care that occurs when the Member is temporarily out of the Service Area under the following conditions:

- The Member's medical condition does not permit the Member's return to the Service Area for treatment; and
- The reason for being outside the Service Area is for some purpose other than the receipt of treatment for a medically related condition.

When this occurs, services will be Covered until the medical condition permits travel or transport back to the Service Area. However, the Plan must be notified by the Member of the treatment within forty-eight (48) hours, condition permitting.

If you are a Member attending college outside of the Service Area, you are required to return to the Service Area and obtain routine and follow-up care from Participating Providers to be eligible for payment at the In-Network benefit level for those Health Services.

1.94 "You or Your"

A Member Covered under this COC.

SECTION 2
USING YOUR BENEFITS

2.1 Membership Identification (ID) Card

Every Member receives a membership ID card. Carry Your ID card with You at all times, and present it whenever You receive Health Services. If Your ID card is missing, lost, or stolen, contact the Member Service Department at the telephone number or web site listed in the Schedule of Important Numbers to obtain a replacement. If Your Dependents are Covered, You will receive one or more additional ID card(s). Enrolled Dependents are listed on ID cards. Your ID card is needed so Providers will bill the Plan and not You for charges other than Copayments, Coinsurance, and non-Covered Services. Each Member must show his or her ID card every time Health Services are requested from Providers. The ID card is needed for Providers to bill the Plan for charges other than Copayments, Coinsurance, and non-Covered Services. If You do not show Your ID card, the Providers have no way of knowing that You are part of the Plan, and You may receive a bill for Health Services.

Possession and use of an ID card is not an entitlement to Coverage. Coverage is subject to verification of eligibility and all the terms, conditions, limitations and exclusions set out in the Agreement.

2.2 Health Services Rendered by Providers

Subject to the terms, conditions, exclusions and limitations of the Agreement, a Member is entitled to Coverage for Health Services described in this COC and the Schedule of Benefits if such services (a) are Medically Necessary and (b) are provided by or under the direction of Your Provider and (c) Authorized in advance on behalf of the Plan. (See Section 6, Covered Services, for information on the services requiring Authorization.) The telephone number for prior Authorization is stated in The Schedule Of Important Telephone Numbers And Addresses, which is attached to this COC, and on the back of any Member's ID card. Please remember that as a Member of a PPO plan, you have the option of receiving your Health Services on either an In-Network basis from Participating Providers or on an Out-of-Network basis from Non-Participating Providers. However, benefits for Health Services rendered by a Non-Participating Provider will be paid at a lower level than those rendered by a Participating Provider. If you consult an Out of Network Provider, the difference between the Plan’s Out of Network Rate and the Provider’s billed charges does not apply to the Deductible. Participating Providers are contractually obligated to file all claims for You.

With respect to transplants, subject to the terms, conditions, exclusions and limitations of the Agreement, a Member is entitled to transplants as described Section 6 of this COC and the Schedule of Benefits if such transplants (a) are

Medically Necessary and (b) ordered by a Coventry Transplant Network Physician and (c) provided at or arranged by a Coventry Transplant Network Facility and (d) Authorized in advance on behalf of the Plan in accordance with the Plan's transplantation guidelines. The telephone number for prior Authorization is stated in The Schedule Of Important Telephone Numbers And Addresses, which is attached to this COC, and on the back of any Member's ID card.

In order to access Your In-Network Benefits You must select a Participating Provider. It is Your responsibility to ensure that the Provider is Participating with Your Plan. This is true for each Provider from whom You may receive Health Services in the course of an entire treatment plan. For example, if You need Health Services and want the highest level of Coverage, You must utilize a Participating Physician. After the Participating Physician has examined You, he or she may recommend that You see a particular specialist. That specialist may or *may not* be a Participating Physician. If You accept the recommendation, and the specialist is not a Participating Physician, then the Health Services You received from the first Physician would be Covered at the (higher) In-Network Benefit level, and the Health Services You received from the specialist would be Covered at the (lower) Out-of-Network Benefit level. Additionally, Providers do not have the authority to independently bind the Plan to Coverage for non-Covered medical services.

In the event that specific Health Services cannot be provided by or through a Participating Provider, You may be eligible for Coverage of Eligible Expenses at the In-Network level for Medically Necessary Health Services obtained through non-Participating Providers if Authorized in advance through the Plan. A Member is entitled to benefits at the In-Network benefit level for Health Services from a Non-Participating Provider only in the case of an Emergency or if a particular Medically Necessary Health Service is not available from a Participating Provider. When Health Services are not available from a Participating Provider, the Plan shall make a referral to an appropriate Provider, pursuant to a treatment plan approved by the Plan in consultation with Your Physician, the Non-Participating Provider and the Member or the Member's designee. The Member will incur no additional cost beyond what the Member would otherwise pay for Health Services received from a Participating Provider.

Coverage for Health Services is subject to timely payment of the Premium required for Coverage under the Plan and payment of the Copayment specified for any service.

2.3 Prior Authorization

It is Your responsibility to ensure all Prior Authorizations have been obtained prior to receiving services. Participating Providers are responsible for obtaining Authorization from the Plan. Members are responsible for verifying that the requested Health Services are Covered under their Plan, and that the required prior Authorization has been granted before receiving the Health Services, when non-Participating Providers are utilized. A verbal Authorization will be confirmed by written Authorization, facsimile transmission, or verbally by means of an Authorization number. Prior Authorization is required for, but is not limited to the following Health Services:

- [All Hospital admissions, including observations;
- All admissions to SNF or inpatient specialty care programs such as rehabilitation; hospice; Mental Health and Substance Abuse;
- Surgical procedures at an outpatient or surgical center;
- Outpatient Mental Health and Substance Abuse Services;
- Pain management, including epidural, facet and trigger point injections;
- Transplants (all phases)
- Rehabilitation/therapy: cardiac, occupational, physical, pulmonary, speech;

The following outpatient diagnostics/services:

- Bone mineral density (all types)
- High level imaging, such as CT scans, MRI/MRA, PET and PET CT scans;
- Cardiac nuclear scans and advanced cardiac imaging;
- Hysteroscopy
- Advanced radiation therapy such as brachytherapy, intense modulated radiotherapy (IMRT), and Proton Beam treatment;
- Chiropractic Services;
- Chemotherapy (off label use only);
- Clinical trials;
- Dialysis;
- Purchased DME over $250 and all rental equipment;

- Experimental or investigational treatments/services;
- Genetic testing, and treatment for genetic disorders;
- All pregnancy related services;
- Ancillary services (including Home Health Care Services, home hospice care, non-Emergency ambulance transfer, Orthotics, and Prosthetics);
- Infertility Services;
- Injectable medications and in-home infusion therapy;
- Implants and related Health Services;
- Lesion removal in office or facility;
- Hyperbaric treatment and;
- Sclerotherapy.]

Please be aware the above is not an all inclusive list. See Section 6 or call Member Services at the number listed in the Schedule of Important Phone Numbers and Addresses for additional information.

Additional Health Services not Covered under the original Authorization will be Covered only if a new Authorization is obtained. All Health Services identified in this COC are subject to all of the terms, conditions, exclusions and limitations of the Plan, even if the Participating Provider obtains an Authorization.

Please refer to Section 6 for a complete list of Health Services requiring Prior Authorization.

2.4 Second Opinion Policy

A Member may seek a second medical opinion or consultation from other Physicians at no additional cost to the Member beyond what he would otherwise pay for an initial medical opinion or consultation. In the event that Member chooses to seek a second medical opinion and the Plan does not employ or contract with another Physician with the expertise necessary to provide a second medical opinion, then the Plan will arrange for a referral to a Physician with the necessary expertise to provide a second medical opinion. In such a case, the Member shall obtain the second medical opinion at no greater cost than if the benefit were obtained from a Participating Provider. The Member may also solicit a second opinion from a Non-Participating Physician of his choice. In this case, the second opinion visit will be Covered at the lower Out-of-Network level of benefits. Second medical opinions or consultations will be subject to all of the terms, conditions, exclusions and limitations of the Plan.

2.5 Authorization

Coverage for certain Health Services set forth in the Schedule of Benefits obtained requires prior Authorization through the Plan. Members are responsible for verifying that the requested Health Services are Covered under their Plan, and the required prior Authorization has been granted before receiving the Health Services. For all other care, You may make an appointment directly with the designated Provider to obtain the Covered Services unless an Authorization is otherwise required in the Schedule of Covered Services. **To receive Coverage at the In-Network benefit level for Health Services from a Provider referred by Your Physician, it is Your responsibility to confirm participation in the Plan.**

The Plan will not retract an approved Authorization after the Health Service has been provided unless:

- Such Authorization is based on a material misrepresentation or omission about the treated person's health condition or the cause of the health condition; or
- The health benefit plan terminates before the Health Service is provided; or
- The Member Coverage under the Plan terminates before the health care services are provided.

Participating Providers do not have the authority to independently bind The Plan to Coverage for medical services that are not Covered Services as described in this COC or mandated by state law. Questions regarding Coverage for services or Provider participation status should be directed to the Plan, not Your Participating Provider. To verify Coverage of services or Provider participation status, please contact Member Services.

2.6 Coverage for Pre-Existing Medical Conditions

Pre-existing Medical Conditions are those condition for which You received medical advice, diagnosis, care, or treatment from an individual licensed or similarly authorized to provide such services under applicable state law within the six (6) month period prior to Your application for Coverage. Pre-existing Medical Conditions may affect Your Premium, may result in denial of Your application, or the Plan may deny Coverage for them for a period of time after Your Member Effective Date. If You are accepted for Coverage, Your Premium will be calculated to include any Pre-existing Medical Condition that You disclosed on Your Enrollment Form and such conditions will be Covered under the terms of Your Contract beginning on Your Effective Date. If you fail to disclose a Pre-existing Medical Condition(s) on your Enrollment Form and You are accepted for Coverage, the Plan may do one of the following:

1. For omissions determined to be fraud as explained in Section 5, the Plan may:
    - terminate Coverage for You and/or all of Your enrolled Dependents at 11:59 p.m. upon the date set forth in the notice of termination to the Subscriber. Such termination may occur back to the original date of enrollment; or

- reevaluate Your medical history and revise Your Premium for Coverage. Such change in premium rate may be enforced back to the original date of enrollment.

2. For omissions determined not to be fraud, the Plan may exclude Coverage for products and services related to Your Pre-Existing Medical Condition for a period not longer than twelve (12) months after Your Effective Date

2.7 Copayments, Coinsurance, and Deductibles

You are responsible for paying Copayments, Coinsurance, and/or Deductible to Providers at the time of service. You must pay Deductible amounts before applicable benefits will be reimbursed to Providers on Your behalf. Specific Copayments, Coinsurance amounts and Deductibles are listed in the Schedule of Benefits.

A copayment may be either a defined dollar amount or a percentage of Eligible Expenses. The total amount a Member pays in Copayments is subject to an Annual Out of Pocket Maximum, as described in the Schedule of Benefits.

2.8 Out-of-Network Rates

Except for Emergency Services, coverage for Covered Services provided by Non-Participating Providers is limited to the Out-of-Network Rate less applicable Copayments, Coinsurance and Deductibles. If you consult an Out of Network Provider, the difference between the Plan's Out of Network Rate and the Provider's billed charges does not apply to the Deductible. In most cases, the Out-of-Network Rate is equivalent to the current Medicare fee schedule for the services and supplies rendered. In all other cases, the Out-of-Network Rate will be determined by the Plan. Please feel free to contact the Plan regarding the Out-of-Network Rate in such cases.

WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE UTILIZED. You should be aware that when You utilize the services of a Non-Participating Provider for a Covered Service, benefit payments to such Non-Participating Provider are not based on the amount billed. The basis of Your benefit payment will be determined according to Your insurance policy. **YOU CAN EXPECT TO PAY MORE THAN THE COINSURNACE AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION AS NON-PARTICIPATING PROVIDERS MAY BILL MEMBERS FOR ANY AMOUNT UP TO THE BILLED CHARGE AFTER THE PLAN HAS PAID ITS PORTION OF THE BILL.** Participating Providers have agreed to accept discounted payments for services with no additional billing to the Member other than Coinsurance and Deductible amounts. Additionally, there may be occasions when You will be required to pay the Non-Participating Provider directly for Covered Health Services rendered. You may obtain further information about the Participating status of Providers and information on out-of-pocket expenses by calling Member Services at the number listed in the Schedule of Important Numbers.

The examples below illustrate how ONR works:

Assume Your Hospital Coinsurance is 20%, the Hospital bill is $5,000 (actual charges), and the ONR for the Hospital is $3,000. In this example, the Plan would not take into account $2,000 of the $5,000 Hospital bill, because it exceeds the $3,000 ONR. The Plan would pay 80% of the $3,000 ONR, which is $2,400. You would pay 20% of the $3,000 ONR, which is $600, ***PLUS*** the $2,000 of actual charges that exceed the $3,000 ONR, for a total cost to You of $2,600. Please note that any payments You make in excess of the ONR do not count towards Your Deductible or Out of Pocket Maximum.

Assume Your Specialist visit Copayment is $50. The Specialist's bill is $140 (actual charges) and the ONR for the Specialist is $80. In this example, The Plan would not take into account $60 of the Specialist's bill because it exceeds the $80 ONR. The Plan would pay $30 (the ONR minus Your Copayment amount). You would pay the $50 Copayment ***PLUS*** the $60 of actual charges that exceed the $80 ONR, for a total cost to You of $110. Please note that any payments You make in excess of the ONR do not count towards Your Deductible or Out of Pocket Maximum.

Please see Your Schedule of Copayments for the Out-of-Network Rates (ONR) for Your plan.

By way of contrast, the examples below illustrate how In-Network Covered Services would be paid:

Assume Your In-Network Hospital Coinsurance is 20%, the Hospital bill is $5,000 (actual charges), and the contracted rate for the Hospital is $3,000. In this example, the Plan would not take into account $2,000 of the $5,000 Hospital bill, because it exceeds the $3,000 contracted rate. The Plan would pay 80% of the $3,000 contracted rate, which is $2,400. You would pay 20% of the $3,000 contracted rate, which is $600. The amount in excess of the contracted rate would not be Your responsibility.

Assume Your Specialist visit Copayment is $50. The Specialist's bill is $140 (actual charges) and the contracted rate for the Specialist is $80. In this example, the Plan would not take into account $60 of the Specialist's bill because it exceeds the $80 contracted amount. The Plan would pay $30 (the contracted rate minus Your Copayment amount). You would pay the $50 Copayment. The amount in excess of the contracted rate would not be Your responsibility.

2.9 Out-of-Pocket Maximum

The Individual Out-of-Pocket Maximum is a limit on the amount You must pay out of Your pocket for specified Covered Services in a Contract Year. The Family Out-of-Pocket Maximum is a limit on the amount Your family must pay out of pocket for specified Covered Services in a Contract Year. The Family Out-of-Pocket Maximum is comprised of the combined charges paid by You and Your

family.

Once the Out-of-Pocket Maximum is met, Covered Services are paid without any Copayment or Coinsurance for the remainder of the Contract Year.

2.10 Maximum Lifetime Benefit

The Maximum Lifetime Benefit payable by the Plan per Member, if applicable, is listed in the Schedule of Benefits.

2.11 Qualified High Deductible Health Plans

If You have a QHDHP, be aware of the following:

- Pharmacy services apply to the medical Deductible. You must satisfy the medical Deductible before benefits apply. Once the Deductible is reached, You may have Copayments and Coinsurance;
- The Deductible does not apply to Preventive Care Services. Benefits apply before the Deductible is satisfied. You may have a Copayment or Coinsurance;
- Copayments do not apply once the maximum out of pocket has been reached.

Be sure you consult Your Schedule of Benefits for information regarding Copayments, Coinsurance and Deductibles.

2.12 Participating Provider Terminations

The Plan or a Participating Provider may end his/her/its relationship with the other. The Plan does not promise that any specific Participating Provider will be available to render services to a Member. The Plan or a Participating Provider may end its relationship with the other after having supplied proper notice under applicable law. Upon the issuance or receipt of such a notice, the Plan will provide a written notice within thirty-one (31) days to all Members who are patients seen on a regular basis by the Participating Provider whose contract is terminating.

Notwithstanding the above, if the continuation of care by a terminated Participating Provider is Medically Necessary and in accordance with reasonable medical prudence, including circumstances such as disability, pregnancy, or life-threatening Illness, You may continue to be Covered for otherwise Covered Services by that Provider if You are:

1. Under active treatment for a particular Injury or Illness. You will continue to receive Covered benefits from the treating Provider for such Injury or Illness for a period of one hundred twenty (120) days from the date of notice of termination;
2. In the second trimester of a pregnancy to continue care with a treating Provider until completion of postpartum care;

3. Being treated at an inpatient facility. You will be allowed to remain at the facility until You are discharged.

The provisions above shall apply only if the treating Provider or inpatient facility agrees to continue to be bound by the terms, conditions and reimbursement rates of the Provider's agreement with the Plan.

During such period of continuation coverage, You shall not be liable to the Provider for any amounts owed for medical care other than Copayments specified under the terms of the Agreement.

2.13 How to Contact the Plan

Throughout this Agreement, You will find that the Plan encourages You to contact the Plan for further information. Whenever You have a question or concern regarding Covered Services or any required procedure, please contact the Plan at the telephone number or web site on the back of Your ID card.

Telephone numbers and addresses to request review of denied claims, register Complaints, place requests for prior Authorization, and submit claims are listed in the Schedule of Important Telephone Numbers And Addresses included in this Agreement.

2.14 Provider Hold Harmless

Participating Providers agree that in no event, including but not limited to nonpayment by the Plan or intermediary, insolvency of the Plan or intermediary, or breach of this Agreement, shall the Participating Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against a Member or a person, other than the Plan or intermediary, acting on behalf of the Member for services provided pursuant to this Agreement. This Agreement shall not prohibit the Provider from collecting Coinsurance, Deductibles or Copayments, as specifically provided in the Schedule of Benefits, or fees for non-Covered Services delivered on a fee-for-service basis to You. The Provider Hold Harmless agreement shall not prohibit a Provider, and You from agreeing to continue services solely at Your expense, as long as the Provider has clearly informed You that the Plan may not cover or continue to cover a specific service or services. Except as provided herein, this agreement does not prohibit the Provider from pursuing any available legal remedy, including but not limited to, collecting from any insurance carrier providing Coverage to a Covered person. Please be advised that the Provider "hold harmless" language does not apply to Out-of-Network (Non-Participating) Providers.

2.15 Plan Has Authority to Grant Coverage

Only Medically Necessary services are Covered under the Agreement. The fact that a Physician or other Provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for an Injury, Illness or substance abuse, or mental Illness does not mean that the procedure or

treatment is Covered under the Agreement. The Plan shall have the right, subject to Your rights in this COC, to interpret the benefits of the COC and attached Riders, and other terms, conditions, limitations and exclusions set out in the Agreement in making factual determinations related to the Agreement, its benefits, and Members; and in construing any disputed or ambiguous terms. In accordance with all applicable law, the Plan reserves the right at any time, to change, amend, interpret, modify, withdraw or add benefits to, or terminate this Plan. The Enrolling Unit will be given the proper written notice upon any termination or change in Coverage as required by applicable law. Any termination of the Agreement must be in accordance with Section 5 of this COC. The Plan may, in certain circumstances, cover services that would otherwise not be Covered. The fact that the Plan does so in any particular case shall not in any way be deemed to require it to do so in other similar cases.

2.16 Coverage for Services by Non-Participating Providers

If You wish to request that the Plan consider reimbursing You for Covered Health Services provided by Non-Participating Providers, You must submit a Non-Participating Provider claim form to the Plan. The Provider may agree to complete and file the claim form for You. If not, You may obtain a Non-Participating claim form from either the Provider or from the Member Services Department. If the claim form is not furnished before the expiration of fifteen (15) days after You receive notice of any claim under the policy, You shall be deemed to have complied with the requirements of the policy as to proof of loss upon submitting, within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which claim is made. The Plan requests that You file the Non-Participating Provider claim within ninety (90) days from date of service. However, failure to file the claim within the ninety (90) day period shall not invalidate or reduce the claim, if it was not reasonably possible to provide notice or proof within the ninety (90) days provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one (1) year from the time proof is otherwise required. A claim will not be denied based upon the Member's failure to submit a claim within the ninety (90) day period unless the failure operates to prejudice the rights of the Plan.

SECTION 3
ENROLLMENT AND ELIGIBILITY

3.1 Eligibility

3.1.1 Subscriber Eligibility - To be eligible to be enrolled You must:

A. Meet all eligibility requirements set forth in this Certificate of Coverage;

B. Be under the age of 65 and not eligible for Medicare;

C. Be a resident of Arkansas residing in the Plan's Service Area;

D. Meet the medical underwriting requirements as explained in Section 3.4 below; and

E. Hold a checking or savings account at a banking institution and agree to direct debit of Your premium payment; and

F. Complete and submit to the Plan such applications or forms that the Plan may reasonably request

Notification of Acceptance and Effective Date of Coverage. Once the Plan receives a completed Application Form and approves the enrollment, The Plan will send You a notification of acceptance notifying You that Your application has been accepted for enrollment in Coventry*One.* You will not be enrolled in Coventry*One u*nless and until You receive such notice. The notice of acceptance renders all terms and conditions of the Contract binding on the Plan, the Subscriber and any accepted Dependent Members. Your payment of the applicable Premium is considered to be your acceptance of Coverage. Coverage shall become effective on the Member Effective Date indicated in the notification of acceptance the Plan sends to You.

3.1.2 Dependent Eligibility - To be eligible to be enrolled under this Agreement as a Dependent, an individual must:

A. Be under the age of 65, and not eligible for Medicare;

- Be the lawful spouse of the Subscriber or be an unmarried child of the Subscriber or the Subscriber's spouse including:
    1. Children up to the age of nineteen (19) who are:
        - the birth children of the Subscriber or the Subscriber's spouse; or
        - legally adopted by or placed for adoption or foster care with the Subscriber or the Subscriber's spouse; and

- unmarried and dependent on the Subscriber for support and maintenance;

2. Children under age of nineteen (19) for whom the Subscriber or the Subscriber's spouse is required to provide health care Coverage pursuant to a Qualified Medical Child Support Order and who are unmarried and dependent on the Subscriber for support and maintenance;

3. Children under age of nineteen (19) for whom the Subscriber or the Subscriber's spouse is the court-appointed legal guardian and who are unmarried and dependent on the Subscriber for support and maintenance;

4. Children under the age of twenty-four (24) who, except for their age, qualify under one of the eligible Dependent categories in subsections 1 – 3 immediately above and who are attending on a full-time basis an accredited educational institution, defined as an educational institution which is eligible for payment of benefits under the Veterans Administration program on a full-time basis, provided that the Subscriber provides documentation of such attendance to the Plan upon request, and at least twice annually. Coverage ends the last day of the month in which the Dependent attains the age of twenty-six (24) or is no longer enrolled in school on a full-time basis. If the Dependent would have been eligible to enroll in such educational institution but was prevented from being enrolled due to illness or injury, then the Dependent shall remain eligible in accordance with the terms of this Section, provided that upon the end of such illness or injury the Dependent must enroll in the educational institution or lose eligibility. The Subscriber must provide evidence of illness or injury to the Plan upon request. Please Note: The Subscriber must advise the Plan within thirty-one (31) days of the student's loss of full-time attendance status;

- Children nineteen (19) or older who are either the birth or adopted children of the Subscriber or the Subscriber's spouse, are mentally or physically incapable of earning a living and who are chiefly dependent upon the Subscriber for support and maintenance, provided that: the onset of such incapacity occurred before age nineteen (19), proof of such incapacity and financial dependence is furnished to the Plan by the

Subscriber upon enrollment of the person as a Dependent child or at the onset of the Dependent child's incapacity prior to age nineteen (19) and annually thereafter after the two (2) year period following the Dependent child's attainment of the attainment of the limiting age

- Children nineteen (19) and older who become handicapped while a Full-time Student;

B. Notwithstanding the above, a common law spouse qualifies as a spouse under this Agreement only if his or her spousal status is affirmed by a court of competent jurisdiction. A domestic partner qualifies as a spouse under this Agreement only by an attached Rider.

C. Meet the medical underwriting requirements as explained in Section 3.4 below.

3.2 Persons Not Eligible to Enroll

3.2.1 A person who fails to meet the eligibility requirements specified in this Agreement shall not be eligible to enroll or continue enrollment with the Plan for Coverage under this Agreement.

3.2.2 A person whose Coverage under this Agreement was terminated due to a violation of a material provision of this Agreement and non-payment of premiums shall not be eligible to enroll with the Plan for Coverage under this Agreement.

3.3 Enrollment

3.3.1 Enrollment Due to New Dependent Eligibility. Subject to the conditions set forth below, a Subscriber and his or her Dependents may apply for Coverage if the Subscriber has acquired a Dependent through marriage, birth, adoption or placement for adoption.

A. <u>New Spouse Acquired Through Marriage</u>. If You get married and your new Spouse applies for Coverage, an Application Form must be submitted to the Plan. The Application Form for Your new spouse is subject to medical underwriting criteria. This means that if Your new spouse does not meet medical underwriting standards, his or her application for Coverage will be declined. Please see Section 3.4 for information on medical underwriting.

B. <u>Special Enrollment for Newborns and Adopted Children</u>.

Dependents shall be Covered under this Agreement as stipulated provided that a child born to You is automatically Covered for the treatment of Injury or Illness, including medically diagnosed congenital defects, birth abnormalities, prematurity and routine nursery care. Application and

applicable Premiums to add the child as a Dependent must be furnished within ninety (90) days from the date of birth. In the case of adoption, the Dependent is Covered from the date of birth, if a petition for adoption is filed within sixty (60) days from the date of birth. Any additional applicable Premiums will apply.

3.3.2 Court Ordered Coverage. A court has ordered coverage be provided for a spouse or minor child under a Covered employee's health benefit plan

3.4 Medical Underwriting

Your eligibility and Premium rates for Coverage under the Agreement are based on health-related factors, but not including genetic testing. An evaluation of Your medical history will determine the Plan's approval of Your enrollment request and Your final Premium rates for Coverage.

The Plan determines the approval of Your application based on review of Your answers on Your Application Form's medical questionnaire. If the Plan needs minor clarification, You will be sent an additional questionnaire and asked that You or Your Dependents complete the form. If detailed information is needed, the Plan will request medical information from the Provider that You listed on Your Application Form or on any additional information You provided. The Plan will any pay fees associated with the procurement of medical records.

If additional information is requested and is not received within forty-five (45) days, the application will be denied.

3.7 Notification of Change in Status.

A Subscriber must notify the Plan of any changes in status or the status of any Dependent within thirty-one (31) days after the date of the qualifying event. This notification must be submitted on a written Application/Change Form to the Plan. Events qualifying as a change in status include, but are not limited to, changes in address, employment, divorce, dependency status, Medicare eligibility or coverage by another payer. The Plan should be notified within a reasonable time of the death of any Member.

SECTION 4
EFFECTIVE DATES

4.1 Effective Dates

A. Notification of Acceptance and Effective Date of Coverage. Once the Plan receives a completed Application Form and approves the enrollment, a notification of acceptance will be sent to the Subscriber notifying the Subscriber that the Plan has accepted the application for enrollment in Coventry*One*. The Subscriber and Dependents will not be enrolled in Coventry*One* unless and until the Subscriber has received such notice. The notice of acceptance renders all terms and conditions of the Contract binding on the Plan, the Subscriber and any accepted Dependent Members. Your payment of the applicable Premium is considered to be your acceptance of Coverage. Coverage shall become effective:

1. In the case of marriage, the first (1st) day of the first (1st) calendar month following the Plan's approval;
2. In the case of a Dependent's birth, the date of such birth;
3. In the case of a Dependent's adoption, the earlier of the date of the final adoption decree or the date of placement in the home; or
4. In the case of a Qualified Medical Child Support Order, the later of:
   (a) the first (1st) day of the month following receipt of the Application Form and approval for enrollment; or
   (b) the Coverage date specified in the order.

   If no date is specified in the order, Coverage shall be effective the later of:
   (i) the first (1st) day of the month following receipt of the Application Form and approval for enrollment; or
   (ii) the date the order is issued by the court.

4.2 Effective Date for Subscribers.

The Plan will notify You when Your application for enrollment in Coventry*One* has been accepted. You will not be enrolled in Coventry*One* unless and until You receive such notice. The Plan will generally approve or decline Your enrollment request within thirty-one (31) days of the Plan's receipt of Your completed Application Form.

Once Your application has been accepted, Coverage shall become effective at 12:00 a.m. on the day specified in the Plan's notice to You.

4.3 Member Effective Date for Dependents.

Dependents who are special enrollees may apply for Coverage as noted in Section 3.3 above, and such Coverage shall be come effective as noted above and in the notice of acceptance.

SECTION 5
TERMINATION AND RENEWAL

5.1 Term

The term of Coverage under the Agreement shall be for one (l) year from the Subscriber's Effective Date, with subsequent annual renewals each Contract Year, at the option of the Member, unless terminated as set forth in this Certificate of Coverage.

5.2 Conditions for Termination of a Member's Coverage Under the Agreement

5.2.1 If Coverage is terminated due to non-payment of Premium, the Plan will provide the Subscriber a grace period of thirty-one (31) days for the payment of any Premium due after the first (1st) Premium payment date. The Coverage may be terminated at the end of the grace period and the services terminated as of the end of the period Covered by the last premium payment. If Covered Services have been rendered during the grace period, Subscriber will be responsible for either the Premium due or the value of services rendered, or claims for services may be denied by the Plan.

5.2.2 The date specified by the Plan in written notice to the Member that all Coverage will terminate because the Member knowingly provided the Plan with false, material information in the written application, including, but not limited to, information relating to another person's eligibility for Coverage or status as a Dependent, or false, material information relating to the Member's basis for obtaining Health Services or health status or that of any Dependent. The Plan has the right to rescind Coverage back to the initial Effective Date. (Please note that no statement voids the Coverage or reduces the benefits after the Coverage has been in force for two (2) years from its initial Effective Date, unless the statement was material to the risk assumed and contained in a written application.) After this policy has been in force for a period of two (2) years during the lifetime of the Member (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application.

5.2.3 The validity of the policy shall not be contested, except for non-payment of Premium, after it has been in force for two (2) years from its date of issue and no statement made by any person covered under the policy shall be used in contesting the validity of the policy during those two (2) years, unless it is contained in a written instrument signed by the person making such statement.

5.2.4 The date specified by the Plan in written notice to the Member that Coverage will terminate because the Member permitted the use of his or her ID card by any unauthorized person or used another person's ID card.

5.2.5 The date a Member no longer lives in the Service Area. The Subscriber is responsible for notifying the Plan of the Member's move from the Service Area. Coverage will terminate on the date of such move, even if the required notice is not provided to the Plan. This Section does not apply to the Dependent child of the Subscriber, as children are not required to live in the Service Area to be enrolled under the Agreement. However, Dependent children who live outside of the Service Area and are enrolled must still follow all the terms and conditions of the Agreement to be Covered for Health Services, except as is otherwise required by federal and state laws and regulations relating to complying with a QMCSO. Members may contact the Plan to coordinate provision of this care as listed in the Schedule Of Important Telephone Numbers And Addresses, or on the back of the Member's ID card.

5.2.6 The date the Plan receives written notice from the Subscriber instructing the Plan to terminate Coverage of the Subscriber or any Member or the date requested in such notice, if later. If the Member receives Covered Services after the termination of Coverage, the Plan may recover the contracted charges for such Covered Services, plus its costs to recover such charges, including attorneys' fees.

5.2.7 The date the Member ceases to be eligible as a Subscriber or Enrolled Dependent, as determined by the Plan. A Member may cease to be eligible if, for example, one of the following events occurs: death of the Subscriber, divorce or legal separation from the Subscriber, or loss of Eligibility by an Enrolled Dependent who is a child (due to reaching the limiting age, marrying, or otherwise failing to meet the definition of Dependent). A child who is a Member through a QMCSO, or court ordered legal guardianship, eases to be eligible on the earliest of the following: a) the date the order is no longer in effect; or b) the date the child has immediate and comparable Coverage under another plan; or c) the date the employee who was ordered to provide health care Coverage ceases to be eligible for Coverage.

In the event of the death of the Member, the proceeds payable to the Member or his/her estate under this policy shall include premiums paid for Coverage for the Member for any period beyond the end of the policy month in which the death occurred. Unearned premiums shall be paid in lump sum on a date no later than thirty (30) days after the proof of the insured's death has been furnished to the Plan.

5.2.8 The date the Member enters active military service and terminates Coverage. Coverage may continue at the option of the Member entering

active military service. If the Member chooses to terminate Coverage, upon notice to the company of termination, the pro rata unearned Premiums shall be refunded. The Member will be given the opportunity to return to the same Coverage.

5.3 Termination of Coverage For Members

You shall no longer meet eligibility requirements upon the occurrence of any one of the following events, or upon the Effective Date of the termination notice provided (if applicable) for such event:

- At least thirty-one (31) days notice of termination of Your Coverage if You no longer meet the eligibility requirements set forth in this Agreement, including, without limitation, living outside the Service Area for a period longer than permitted under this Agreement.
- At least thirty-one (31) days notice of the termination of Your Coverage due to the non-payment of Premiums or supplemental charges (Copayments) required for Hospital or medical services;
- At least thirty-one (31) days written notice if You participate in fraudulent or criminal behavior, including but not limited to:
  - Performing an act or practice that constitutes fraud or intentionally misrepresenting material facts including using Your ID card to obtain goods or services which are not prescribed or ordered for You or to which You are otherwise not legally entitled. In this instance, Coverage for the Subscriber and all Dependents will be terminated.
  - Allowing any other person to use Your ID card to obtain services. If a Dependent allows any other person to use his or her ID card to obtain services, the Coverage of the Dependent who allowed the misuse of the card will be terminated. If the Subscriber allows any other person to use his or her ID card to obtain services, the Coverage of the Subscriber and his or her Dependents will be terminated.
  - Threatening or perpetrating violent acts against the Plan, a Provider, or an employee of the Plan or a Provider. In this instance, Coverage for the Subscriber and all Dependents will be terminated.
  - Knowingly misrepresenting or giving false information on any application form which is material to a Member's eligibility for Coverage, status as a Dependent, basis for obtaining Health Services, or health status.

5.4 Effect of Termination.

- If Your Coverage under this Agreement is terminated under this Section and other Coverage is not available, all rights to receive Covered Services shall cease as of the date of termination.
- ID cards are the property of the Plan and, upon request, shall be returned to

the Plan within thirty-one (31) days of the termination of Your Coverage. ID cards are for purposes of identification only and do not guarantee eligibility to receive Covered Services.

- Your Coverage cannot be terminated on the basis of the status of Your health or the exercise of Your rights under the Plan's Complaint and Grievance procedures. The Plan may not terminate an Agreement solely for the purpose of effecting the disenrollment of an individual Member for either of these reasons.

5.5 Discontinuation of Coverage

If the Plan decides to discontinue this COC, You will receive a written notice of discontinuation at least ninety (90) days before the date the Coverage will be discontinued and You will be offered the opportunity, on a guaranteed issue basis, to purchase for You any other coverage offered by the Plan. If the Plan elects to discontinue offering all health insurance coverage in the individual market, You will receive a written notice of discontinuation at least one hundred and eighty (180) days before the date the Coverage will be discontinued

SECTION 6
COVERED SERVICES

The Plan covers only those Health Services and supplies that are (1) deemed Medically Necessary, (2) Authorized, if Authorization is required, and (3) not excluded under the exclusions and limitations set forth in Section 8. Health Services are Covered at a reduced or standard percentage under the Out-of-Network benefit outlined in the Schedule of Benefits when Medically Necessary, provided by a Non-Participating Provider, and not excluded as described in Section 7.

The following section, **Schedule of Covered Services**, provides the Health Services and supplies Covered under this Agreement. The schedule is provided to assist You with determining the level of coverage and Authorization procedures, limitations, and exclusions that apply for Covered Services when determined to be Medically Necessary, subject to the exclusions and limitations set forth in Section 8 and any Copayments, Coinsurance or Deductibles as outlined in Your Schedule of Benefits. All Prior Authorizations and determinations referenced in the Schedule of Covered Services are made by the Plan. If a service is Medically Necessary but not specifically listed and not otherwise excluded, please contact the Plan to confirm whether the service is a Covered Service.

The differences in Coverage between the In-Network and the Out-of-Network benefit levels, including any Coinsurance, Copayment, or Deductible amount You are required to pay for each Covered Health Service is stated in the Schedule of Benefits. The Copayment amount You are required to pay for each Covered Health Service is stated in the Schedule of Benefits. However, if a Member requires Emergency outpatient services and supplies, the required Copayment for Emergency outpatient services and supplies will not apply if Confinement occurs for the same condition within twenty-four (24) hours.

The network of Participating Providers available to You under this Plan is listed in the Provider Directory provided on the Plan website. The Provider Directory is given to Members upon request, and is available on the Plan's web site. It is therefore important that You carefully review Your Provider Directory. Listing a particular Provider in the Provider Directory is not a guarantee that the particular Provider will be participating at the time You seek Health Services. You must verify the participation status of Providers with the Plan before You obtain Health Services.

Except where noted, these Health Services are Covered when rendered by either Participating or Non-Participating Providers. Please remember that Health Services rendered by Non-Participating Providers will be Covered at the lower Out-of-Network level and Authorized if Authorization is required.

Please note that the Covered Services in the schedule below are subject to all applicable Exclusions of this COC.

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Allergy	Covered Service for allergy testing, diagnosis, treatment, allergy serum, and the administration of injections. Coverage is provided for allergy services and supplies ordered by and provided by or under the direction of a Physician in the Provider's office.	Prior Authorization may be required. **Exclusions:** Those non-Physician allergy services or associated expenses relating to an allergic condition including, but not limited to, installation of air filters, air purifiers, or air ventilation system cleaning.
Ambulance	Coverage is provided for Emergency ambulance transportation, when transport by other means is not medically safe, by a licensed ambulance service to the nearest Hospital where Emergency Health Services can be rendered.	Prior Authorization required unless emergent in nature. All air or ground ambulance transfer between facilities requires Prior Authorization. **Exclusions:** Ambulance transportation due to the absence of other transportation on the part of the Member is excluded. Non-Medical Emergency ambulance services are excluded regardless of who requested the ambulance service.

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Blood and Blood Products	Covered Service for administration, storage, and processing of blood and blood products in connection with Covered services.	**Exclusions:** Those services and associated expenses related to personal blood storage, unless associated with a scheduled surgery. Additionally, fetal cord blood harvesting and storage is not a Covered Service.
Breast Reconstruction	Coverage is provided for breast Reconstructive Surgery and prosthesis following a Medically Necessary mastectomy. As required by the Women's Health and Cancer Rights Act ("WHCRA"), if You elect breast reconstruction after a Covered mastectomy, benefits will be provided for augmentation and reduction of the affected breast, augmentation or reduction on the opposite breast to restore symmetry, prosthesis, and treatment of physical complications at all stages of the mastectomy, including lymphedema. This also includes nipple reconstruction. In lieu of surgery, Coverage is provided for external Prosthetic Devices.	Prior Authorization required. **Exclusions:** Reduction or augmentation mammoplasties unrelated to a Medically Necessary mastectomy. There is no Coverage for surgery performed for removal of breast implants that were originally implanted solely for cosmetic purposes.
Cardiac Rehabilitation Therapy	Covered Service, but limited to treatment for therapy conditions that in the judgment of Your Physician and the Medical Director are subject to significant improvement of Your condition through relatively short-term therapy.	Prior Authorization required. **Limitations:** Limited to 36 Phase II visits in a 12-week period. **Exclusions:** Phase III (maintenance phase) Cardiac Rehabilitation.

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Chemotherapy and Radiation therapy	Standard chemotherapy and radiation therapy, for the treatment of cancer.	Prior Authorization may be required. **Exclusions:** Experimental or Investigational or non-standard chemotherapy or radiation therapy.
Child Health Supervision Services	Coverage is provided for the periodic review of a child's physical and emotional status by a Physician or pursuant to a Physician's supervision. A review shall include a history, complete physical examination, development assessment, anticipatory guidance, appropriate immunizations and laboratory tests consistent with prevailing standards, including testing for lead poisoning for children under the age of six (6). Periodic reviews are Covered (up to 20 visits) from the date of birth through the age of eighteen (18) years at the following intervals: birth, two weeks, two month, four months, six months, nine months, twelve months, fifteen months, eighteen months, two years, yearly after age two years until age six (6), and every two years after age six(6) up to age eighteen (18). Coverage is also provided for the treatment of autism spectrum disorders for Members under twelve (12) years of age.	
Chiropractic Services	Medically Necessary and clinically appropriate Chiropractic therapy is Covered.	Prior Authorization is required. **Limitations:** The therapy rendered must be within the Chiropractor's lawful scope of practice.

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Clinical Trials	Coverage for routine patient care costs related to phase I, II, III or IV clinical trials is limited to cancer treatment. The treatment shall be provided in a clinical trial that either: • Involves a drug that is exempt, under federal regulations, from new drug application; or • Is approved by the following: 1. One of the national institutes of health; 2. The Food and Drug Administration (FDA) in the form of an investigational new drug application; 3. The Veteran's Administration or Defense Department. Routine patient care costs are those costs associated with the provision of health care services including services that are: 1. Typically provided absent a clinical trial; 2. Required solely for the provision of the drug, medical device or service; 3. Required for the clinically appropriate monitoring of the drug, medical device, or service; 4. Provided for the prevention of complication arising from the provision of the drug, medical device, or service; and Needed for the reasonable and necessary care arising from the provision of the drug, medical device, or service including the complications.	**Limitations:** Prior Authorization will be required by the Plan. Coverage is based on the commercial benefit at the time the Member is enrolled in a clinical study at a participating medical center. Should a patient choose to enroll in a study at a non-participating center, Coverage will be limited to the level that would be incurred at the nearest participating center in the Member's Service Area. Any case that can be safely delegated to Participating Physicians, in the event that the Member is receiving care by a Non-participating Provider, will be required to receive the In-Network benefit. **Exclusions:** The cost of any non-health care services that a member may require in conjunction with the clinical trial (e.g. transportation, lodging, custodial care) and the administrative costs associated with managing the clinical trial.

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Clinical Trials (cont)		Coverage is excluded for any clinical trials treatment of cancer that are not sanctioned by the listed organizations. Coverage for the cost of investigational drug(s) is excluded. Coverage is also excluded for services not Covered under the Member's policy for non-investigational treatment (e.g. cosmetic surgery, custodial care) or costs in conjunction with the clinical trial (e.g. transportation, lodging, custodial care).
Colorectal Cancer Screening	Coverage is provided for a colorectal cancer screening for Members who are fifty (50) years of age and older, Members who are at high risk for colorectal cancer according to the American Cancer Society colorectal cancer screening guidelines, and Members experiencing symptoms of colorectal cancer as determined by their Physician. Screening shall include: 1. An annual fecal occult blood test; OR 2. An annual fecal immunochemical test in conjection with a flexible sigmoidoscopy every five (5) years; OR 3. A double-contrast barium enema every five (5) years; OR A colonoscopy every ten (10) years.	

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Contraceptive Devices	Contraceptive implants & IUD's are covered. Contraceptive supplies and devices obtained at a pharmacy are determined by the applicable pharmacy Rider.	
Cosmetic, Plastic and Related Reconstructive Surgery	Services are limited to the surgical correction of congenital birth defects or the effects of disease or Injury, which cause anatomical functional impairment, when such surgery is reasonably expected to correct the functional impairment. For purposes of this Agreement, psychological or emotional conditions do not constitute Medical Necessity.	Prior Authorization required.

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Dental Services	Coverage benefit limited to the Emergency treatment as a result of trauma resulting in fracture of jaw or laceration of mouth, tongue, or gums. Services are Covered for the removal of tumors and cysts of the jaws, lips, cheeks, tongue, roof and floor of the mouth, and removal of bony growths of the jaw, soft and hard palate and Medically Necessary reconstructive surgery of the jaw for repair of traumatic injury. Separate of, and in addition to, the accident-related dental services described above, there shall also be Coverage for the administration of general anesthesia (regardless of whether the dental services are provided in a Hospital, surgical center or Physician's office), and Hospital charges for dental care provided to the following Members when Authorized in advance by the Plan and, (1) A child under the age seven (7); (2) A person with a diagnosed serious mental or physical condition; or 3) A person with a significant behavioral problem.	Limited benefit. Prior Authorization required. **Exclusions:** Not a Covered Service for the care, treatment, filling, removal, replacement, repair, or artificial restoration of the teeth (either natural or artificial), root canal, surgery for impacted teeth, surgery involving structures directly supporting the teeth, dental implants or orthodontia. Removal of teeth due to an Injury, prior to radiation or for radionecrosis is also not a Covered Service. General anesthesia and facility charges do not apply to treatment of temporomandibular joint disorders. The diagnosis and treatment for temporomandibular joint disease (TMJ) and craniomandibular joint disease is not Covered unless by an attached Rider.

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Dental Services (cont.)		Those dental services provided by a Doctor of Dental Surgery, "D.D.S.," a Doctor of Medical Dentistry "D.M.D." or a Physician licensed to perform dental related oral surgical procedures (including services for overbite or underbite,) whether the services are considered to be medical or dental in nature except as provided in this section. Dental x-rays, supplies and appliances (including occlusal splints and orthodontia). Removal of dentiginous cysts, mandibular tori and odontiod cysts are excluded as they are dental in origin.
Dermatological Services	Covered Service when necessary to remove a skin lesion that interferes with normal body functions or is suspected to be malignant.	Prior Authorization may be required. **Exclusions:** The removal or destruction of skin tags is not Covered. Benign pigmented nevi, sebaceous cysts and seborrheic keratosis that cause no functional impairment are not Covered.

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Dialysis	Covered Service for hemodialysis and peritoneal services provided by outpatient or inpatient facilities or at home. For home dialysis, equipment, supplies, and maintenance will be a Covered Service.	
Diabetic Supplies	Coverage includes Plan approved glucose meters (including those for the legally blind), insulin pumps, infusion devices and appurtenances thereto and self-management training (including medical nutrition counseling) used in connection with the treatment of Type I, Type II and gestational diabetes. Coverage also includes diabetes self-management training as Medically Necessary provided by an appropriately licensed health care professional.	Prior Authorization required for insulin pens, pumps, cartridges, extended education classes, and glucose meters. **Limitations:** Disposable insulin syringes, glucose strips, and lancets are Covered under a Pharmacy Rider (if purchased).
Durable Medical Equipment (DME)	Covered Service when determined to be necessary and reasonable for the treatment of an Illness or Injury, or to improve the functioning of a malformed body part, and when all of the following circumstances apply:	Prior Authorization may be required. Upgrades to equipment are the responsibility of the Member.

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Durable Medical Equipment (DME) (cont.)	(1) It can withstand repeated use; (2) It is primarily and customarily used to serve a medical purpose; (3) It is generally not useful to a person in the absence of Illness or Injury; (4) It is appropriate for use in the home; and (5) Member is compliant with its use as prescribed by the treating Physician. There is Coverage for the initial rental and purchase of Durable Medical Equipment when Authorized in advance by the Plan, obtained from a vendor or Provider selected or approved by the Plan, and ordered by or provided by or under the direction of a Provider for use outside a Hospital or SNF. Coverage is provided for Durable Medical Equipment that meets the minimum specifications that are Medically Necessary. Coverage includes, but is not limited to the following: standard wheelchairs; standard Hospital-type beds; Plan approved glucose meters; continuous passive motion devices after surgery; initial placement of elastic garments; oxygen and the rental of equipment for the administration of oxygen; mechanical equipment necessary for the treatment of chronic or acute respiratory failure (ventilators and respirators). Coverage will be provided for replacement of Durable Medical Equipment which has become non-functional and non-repairable due to normal, routine wear and tear, medical necessity, or documented growth of a child. Modification costs necessitated by change in the Member's medical condition and considered by the Plan to be Medically Necessary, are Covered.	**Exclusions:** Durable Medical Equipment that does not serve a medical purpose or cannot be used in a Member's home, equipment that is generally not useful to a person without Illness, Injury or diseases. The purchase or rental of supplies of common household use such as exercise equipment, air purifiers, central or unit air conditioners, allergenic pillows or mattresses and beds. Over-the-counter devices and/or supplies (such as ACE wraps, disposable medical supplies, elastic supports, finger splints, Jobst and TEDS stockings, and soft cervical collars). Advanced versions of devices are not Covered.

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Durable Medical Equipment (DME) (cont.)		Those repairs, replacement, or maintenance costs for any otherwise Covered DME except as provided as a Covered service; maintenance due to normal wear and tear of items owned by the Member; personal comfort items, including air conditioners, humidifiers and dehumidifiers, even though prescribed by a Physician, unless defined as Covered Services. This exclusion also applies to disposable medical supplies, including but not limited to, feeding bags, and feeding syringes. However, modification or replacement costs necessitated by change in the Member's medical condition and considered by the Plan to be Medically Necessary, are Covered if the original equipment was Covered.

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Emergency Services	Covered Service as set forth in Section 1.35 and 7.1 below. The Plan definition of "Emergency Services" is found in the definition section. Services and supplies furnished or required to screen and stabilize an Emergency medical condition provided on an outpatient basis at either a Hospital or an Alternate Facility are Covered. An additional Copayment will not apply if a recurrent Emergency Room visit occurs for the same condition within twenty-four (24) hours.	While Emergency Services do not require Prior Authorization from or notification to the Plan, You should notify Your Physician within 48 hours of the onset of the Emergency or the next business day or as soon as physically able. **Limitations:** If You are sent to Surgery from the ER and the facility bills as Outpatient Surgery, Your Outpatient Surgery Copayment or Coinsurance may apply. Please refer to Your Schedule of Benefits.
Eyeglasses and Corrective Lenses	Not a Covered Service, except when necessary for the first pair of select eyeglasses or corrective lenses following cataract surgery performed while You are enrolled with the Plan. Coverage is provided for one (1) annual eye examination per Member for the purpose of determining vision loss or disease (including refraction) provided by the Plan's designated vision provider.	**Limitations:** Coverage at the in-network benefit level is available only when services are provided by the Plan's designated vision provider. **Exclusions:** Those charges incurred in connection with the provision or fitting of eyeglasses or contact lenses, except for initial placement immediately after cataract surgery**.**

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Genetic Counseling	Covered Services include counseling and routine genetic tests performed by the Plan's reference lab when a Member has delivered or suspected to deliver an infant with suspected genetic abnormalities.	Prior Authorization required. **Exclusions:** Not covered to diagnose multiple fetuses.
Genomics	Genomics are Covered only by Prescription Rider for the FDA indication and approved dosing.	**Limitations:** Covered only by Prescription Rider. Must be Prior Authorized by the Plan.
Gynecological Examinations	Coverage is provided for one annual self-referred well-woman examination for each female Member, including services, supplies and related tests by an obstetrician, gynecologist or obstetrician/gynecologist, in accordance with the current American Cancer Society guidelines. Diagnosis, including bone mass measurement, treatment and appropriate management for osteoporosis is provided when determined to be Medically Necessary by a physician. Bone mass measurement is cover testing is Covered only for spine or pelvic testing. Coverage is provided for an annual chlamydia screening for Members the age of twenty-nine (29) and younger.	Exclusions: Peripheral bone mass measurement testing is not Covered.
Health Education	Covered Service includes instructions on achieving and maintaining physical and mental health, and preventing Illness and Injury.	Health education does not require Prior Authorization by the Plan when provided in the Physician's office.

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Hearing Screenings	One (1) annual hearing screening per Member for determining hearing loss is Covered. Medically Necessary treatment for hearing loss is also Covered. Hearing aids are Covered up to an amount as specified in Your Schedule of Benefits.	This benefit will be subject to the same durational limits, dollar limits, Copayment, Deductible, and Coinsurance as other Covered services.
Home Health Care Services	Covered Service when all of the following requirements are met: (1) The service is ordered by a Physician; (2) Services required are of a type which can only be performed by a licensed nurse, physical therapist, speech therapist, or occupational therapist; (3) The services are a substitute or alternative to Hospitalization; (4) Part-time intermittent services are required; (5) A treatment plan has been established and periodically reviewed by the ordering Physician; (6) The services are Authorized by the Plan; and (7) The agency rendering services is Medicare certified and licensed by the State of location; and (8) The Member is homebound.	Prior Authorization required.

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Hospice	Coverage is provided for hospice care rendered by a Provider for treatment of a terminally ill Member when Authorized by Your Physician. Skilled care through a hospice program includes supportive care involving the evaluation of the emotional, social and environmental circumstances related to or resulting from the Illness, and guidance and assistance during the Illness for the purpose of preparing the Member and the Member's family for imminent death when the Member has a prognosis of six (6) months or less to live.	Prior Authorization required.
Immunizations	Immunizations are Covered for children pursuant to the Plan's criteria, which uses national standards (approved by the Advisory Committee on Immunization Practices, the American Academy of Pediatrics, the American Academy of Family Physicians, and the Guide to Clinical Preventative Services, Report of the United States Preventative Services Task Force) to establish eligibility guidelines. Adult immunizations are Covered as per guidelines of the Center for Disease Control (CDC) and the U.S. Taskforce of Preventive Guidelines. This program is fully compliant with the minimum Coverage requirements of State law. Please refer to the Member Handbook for further information on Covered immunizations Immunizations for children shall be exempt from any Copayment, Coinsurance, Deductible or dollar limitation.	Prior Authorization required for immunizations other than routine childhood immunizations (e.g., Lyme Disease).

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Implants and Related Health Services	Implant devices and related implantation Health Services including penile implants (unless prescribed to treat impotence which is psychological in origin), implants for the purpose of contraception, and implants for the delivery of Prescription Medication when provided by or under the direction of Your Physician, in accordance with the Plan's guidelines and approved in advance by the Plan, are Covered.	Prior Authorization required. **Limitations:** Penile implants are limited to one (1) per Lifetime. **Exclusions:** There is no Coverage for either dental, breast, cochlear (including services related to cochlear implants), or nanometric implants. This list also includes, but is not limited to, VNS (vagal nerve stimulator) implants. Covered implants, except when necessitated due to a change in the Member's medical condition.

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Infertility	Medically Necessary diagnostic studies which are related to Infertility are Covered once per Lifetime. Members may self-refer to any obstetrician, gynecologist or obstetrician/gynecologist for Covered services. Coverage for in vitro fertilization when: 1. The Member's occytes are fertilized with the spouse's sperm; and 2. The Member and the Member's spouse have a history of unexplained infertility of at least two (2) years duration; or 3. The infertility is associated with endometriosis, exposure in utero to Diethylstilbestrol (DES), blockage of or removal of one of both fallopian tubes not a result of voluntary sterilization, or abnormal male factors contributing to the infertility; and 4. Member has been unable to obtain a successful pregnancy through less costly infertility treatment.	Prior Authorization required. **Limitations:** Benefit is limited to $15,000 per Lifetime. **Exclusions:** Therapeutic services and treatment related to Infertility are not Covered except by an attached Rider to the Agreement.
Injectable Medications	Medically Necessary injectable medications are Covered when FDA-approved and medically appropriate, subject to limitation by pre-Authorization and substitute Coverage by therapeutically interchangeable drugs, according to clinical guidelines used by the Plan. For Coverage of medications that are self-injectable, please see "Self-Injectable Medications" in this Section.	Prior Authorization required.

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Inpatient Hospital Care	Coverage includes: general nursing care; use of operating room, surgical and anesthesia services and supplies; blood and blood products; ordinary casts, splints and dressings; all drugs and oxygen used in Hospital; laboratory and X-ray examinations; electrocardiograms; Semi-private Accommodations, Intensive Care Unit, and Coronary Care Unit. Consistent with the Plan's utilization management policy, all acute care Hospital admissions and continued stays are reviewed for Medical Necessity during the inpatient stay. Coverage is dependent on the establishment of Medical Necessity for the care. If the Hospital stay or portion thereof is determined not to be Medically Necessary, Your Provider will be notified that Coverage will cease. Certain Health Services rendered during a Member's Confinement are subject to separate benefit restrictions and/or Copayments as described in the Schedule of Benefits and Schedule of Exclusions.	Prior Authorization required unless Emergency admission. **Exclusions:** Except where the Plan has given specific Authorization, You must be admitted to a Participating Hospital and be under the care of a Participating Provider to be eligible to receive In-Network level of benefits for non-Emergency Covered Services. Those personal comfort and convenience items or services such as television, telephone, barber or beauty service, guest service and similar incidental services and supplies. Additional elective, not Medically Necessary surgical procedures are not Covered.
Laboratory Services	Covered Service.	You may have a Copayment, Coinsurance and Deductible depending on Your benefits. Please refer to Your Schedule of Benefits.

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Mastectomy	Medically Necessary mastectomies are Covered. If a Member elects breast reconstruction following a Medically Necessary mastectomy, the following benefits are also Covered: • Reconstruction of the affected breast; • Surgery and reconstruction of the other breast to produce a symmetrical appearance; • Prostheses; and • Treatment of physical complications at all stages of the mastectomy, including lymphedemas.	Prior Authorization required. **Limitations:** Two (2) Mastectomy bras per calendar year/Contract Year. Surgery to establish symmetry must occur within five (5) years of the date the reconstructive surgery was performed.

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Medical Complications	Complications arising from Medically Necessary surgery regardless of the membership status at the time of surgery. Complications of pregnancy will be Covered.	Prior Authorization Required. **Exclusions:** If complications occurred when You did not follow the course of treatment prescribed by Your Provider, although the requested service may be Medically Necessary, or if the complication is from a non-Covered Service, the requested service will not be Covered, including, but not limited to, complications as a result of a clinical trial or experimental procedure.
Medical Services in a Physician's Office	Coverage is provided for services and supplies ordered and provided by or under the direction of Your Physician in the Physician's office, including preventive medical care such as well-baby care, routine physical examinations, and Immunizations. Certain Health Services provided in a Physician's office are subject to separate benefit restrictions and/or Copayments as described elsewhere in this COC or in the Schedule of Benefits.	
Mental Health	Covered with an attached Rider only.	

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Newborn Care	The Covered Services for eligible newborn children shall consist of Coverage for Injury or Illness, including Medically Necessary care or treatment of medically diagnosed congenital defects, birth abnormalities, or prematurity, and transportation costs of the newborn to and from the nearest facility that is appropriately staffed and equipped to treat the newborn's condition. Coverage is provided for all newborns to be tested or screened for phenylketonuria (PKU), hypothyroidism, galactosemia, sickle cell anemia and all other disorders of metabolism for which screening is performed by or for the State of Arkansas. Routine nursery care for a well newborn child is Covered up to five (5) full days or until the mother is discharged whichever is the lesser period of time. Coverage is also provided for newborn hearing screening examinations, any necessary re-screening, audiological assessment and any requisite follow-up.	Prior Authorization is required for non-emergency or non-urgent transportation to another facility.
Nutritional Counseling	Covered Service when: (1) provided by a Registered Dietician or a Physician and (2) in connection with diabetes, coronary artery disease and hyperlipidemia.	
Oral Surgery and Diseases of the Mouth	Coverage includes only Authorized oral surgical services limited to the reduction or manipulation of fractures of facial bones; excision of lesions of the mandible, mouth, lip, or tongue; incision of accessory sinuses, mouth, salivary glands, or ducts; reconstruction or repair of the mouth or lip necessary to correct anatomical functional impairment caused by congenital defect. Coverage is provided for diseases of the mouth, unless the condition is due to dental disease or of dental origin.	Prior Authorization required. **Exclusions:** Removal of dentiginous cysts, mandibular tori and odontoid cysts are excluded as they are dental in origin. Removal of teeth as a complication of radionecrosis is not a Covered benefit.

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Outpatient Diagnostic Tests and Therapeutic Treatments	Coverage includes services and supplies for prescheduled diagnostic tests and therapeutic treatments provided under the direction of Your Physician at a Hospital or Alternate Facility.	Prior Authorization may be required.
Outpatient Surgery	Coverage is provided for services and supplies for Emergent, Prior Authorized, and prescheduled outpatient surgery provided under the direction of Your Physician at a Hospital or Alternate Facility.	Prior Authorization required.
Pelvic Examinations and Pap Smears	Coverage is provided for a self-referred pelvic examination and cervical screening for asymptomatic women, in accordance with the American Cancer Society guidelines.	
Phenylketonuria (PKU) or any other Amino and Organic Acid Inherited Disease Food	Coverage is provided for medical foods and low protein modified food products for treatment of a Member diagnosed with PKU, galactosemia, organic acidemias and disorders of amino acid metabolism if: 1. The products are medically necessary and prescribed and administered under the direction of a licensed Physician; and The cost of the food and food products for a Member exceeds the income tax credit of $2,400.	Prior Authorization required.
Podiatry	Covered Service when determined to be Medically Necessary. Covered Service for regular foot exams if You have diabetes, or when otherwise determined to be Medically Necessary.	Prior Authorization may be required. **Exclusions:** Foot care in connection with clipping nails or treating corns, calluses, flat feet, fallen arches or chronic foot strain. Medical or surgical treatment of onychomycosis (nail fungus). Shoe inserts or Orthotics are also excluded.

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Preventive, Diagnostic and Treatment Services	Office visits to a Your Physician for Covered Services and includes: • Preventive care, including well-baby care and periodic check-ups according to the preventive care guidelines adopted by the Plan. The Plan's guidelines are available in your Member Handbook, on the Plan's website or from Member Services upon request. • Diagnosis and treatment of Illness or Injury. • Consultations with Specialists. • Laboratory tests Prostate Specific Antigen (PSA) test, and digital rectal examinations, for the early detection of prostate cancer for men aged fifty (50) and over and other men if a Physician determines that early detection for prostate cancer is medically necessary. A baseline mammogram will be covered for women between thirty-five (35) and forty (40), every one (1) to two (2) years, or more frequently based on the recommendation of the woman's physician, for women between forty (40) and forty-nine (49), and yearly age fifty (50) and older. Mammograms will be Covered more frequently upon the recommendations of the woman's Physician. Diagnosis, including bone mass measurement,, treatment and appropriate management for osteoporosis is provided when determined to be Medically Necessary by a physician.	

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Prostate Screening	Coverage is provided for a prostate-specific antigen (PSA) exam and digital rectal exam for the early detection of prostate cancer for men aged fifty (50) and over and other men if a Physician determines that early detection for prostate cancer is Medically Necessary.	

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Prosthetic and Orthotic Devices	Coverage is provided for the initial purchase of Orthotic Appliances and Prosthetic Devices following the onset or initial diagnosis of the condition for which the device is required. These services must be Authorized in advance by the Plan and obtained for use outside a Hospital or a SNF. Coverage is provided for Orthotic Appliances, splints and braces, including necessary adjustments to shoes to accommodate braces (dental braces are excluded). Coverage is provided for Prosthetic Devices, including but not limited to, purchase of artificial limbs, breasts, and eyes, which meet the minimum requirements or specifications which are Medically Necessary for treatment, limited to the basic functional device which will restore the lost body function or part. For Prosthetic Device placements requiring a temporary and then a permanent placement only one (1) device will be Covered. Shoe inserts or Orthotics will be Covered only if the Member has diabetes to prevent complications associated with diabetes OR the Orthotic is needed for a shoe that is part of a brace. Coverage will be provided for replacement of Prosthetic Devices, which become non-functional and non-repairable due to normal, routine wear and tear, Medical Necessity or documented growth of a child. Modification costs necessitated by change in the Member's medical condition and considered by the Plan to be Medically Necessary, are Covered. .	Prior Authorization required. If You require refitting and a replacement due to structural change in anatomy, the replacement must be Prior Authorized. **Exclusions:** No Coverage is provided for repair, or duplicates nor is Coverage provided for Health Services related to any repair. Over the counter braces, splints and Orthotics are not Covered. Advanced versions of devices are not Covered. Orthopedic shoes are not Covered. Cranial helmets are not Covered, unless the congenital defect of the skull adversely effects normal brain, auditory, visual or central nervous system development. Shoe inserts are not Covered unless the Member has diabetes with demonstrated peripheral neuropathy or the insert is needed for a shoe that is part of a brace.

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Prosthetic and Orthotic Devices (cont)	Orthotics and Prosthetics will be replaced yearly for documented growth in a child requiring replacement, but not for changes due to obesity. Eye Prosthetics will be Covered for replacement every five (5) years with exceptions allowed when documentation supports Medical Necessity for more frequent replacement. Polishing and resurfacing is Covered on a yearly basis.	
Pulmonary Rehabilitation Therapy	Covered Service, but limited to treatment for conditions that in the judgment of Your Provider and the Medical Director are subject to significant improvement of Your condition through relatively short-term therapy.	Prior Authorization required. **Limitations:** Limited to one treatment program up to a maximum of 36 visits.
Radiology	Covered Service.	Prior Authorization is required for CAT scans, MRIs, and PET scans.
Reconstructive Surgery	Covered Service for Medically Necessary: • Surgery which is incidental to an Injury, Illness or congenital anomaly when the primary purpose is to restore normal physiological functioning of the involved part of the body; or • Surgery that substantially improves functioning of any malformed body part.	Prior Authorization required.

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Rehabilitation Services and Supplies	Coverage is provided for short-term inpatient or outpatient (whichever is Medically Necessary) rehabilitation services which are expected to result in significant functional improvement within sixty (60) days of the Member's condition, limited to physical therapy, occupational therapy, and speech therapy. Combined rehabilitation services include physical therapy, occupational therapy, and speech therapy. All combined services are Covered up to a maximum of sixty (60) inpatient days, sixty (60) outpatient visits, or a combination of both not to exceed sixty (60) days/visits per year. Outpatient rehabilitation services include Medically Necessary Covered Services, supplies, and related Physician and facility charges and must be provided under the direction of Your Physician and Authorized in advance by the Plan.	Prior Authorization required. **Exclusions:** 1. Rehabilitative services provided for long-term, Chronic Medical Conditions. 2. Rehabilitative services whose primary goal is to maintain Your current level of function, as opposed to improving Your functional status. 3. Rehabilitative services whose primary goal is to return You to a specific occupation or job, such as work-hardening or work-conditioning programs. 4. Educational or vocational therapy, schools or services designed to retrain You for employment. 5. Rehabilitative services whose purpose is to treat or improve a developmental or a learning disability or delay, mental retardation, cerebral palsy, or congenital anomalies.

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Rehabilitation Services and Supplies (cont.)		6. Rehabilitation services that are experimental or have not been shown to be clinically effective for the medical condition being treated. 7. Alternative rehabilitation services (*e.g.*, massage therapy). 8. Fees or costs associated with services that are primarily exercise. Examples include, but are not limited to, membership fees for health clubs, fitness centers, weight loss centers or clinics, or home exercise equipment. 9. Health Services for the diagnosis and treatment of chronic brain Injury, including augmentative communication devices, developmental delay, mental retardation or cerebral palsy are not Covered.
Second Opinion	Covered Service as per Section 2.4 of this COC.	

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Services Provided to Residents of Long-term Care Facilities	If the Member is a resident of a long-term care facility licensed by Arkansas or a continuing care retirement community, such Member has the option of receiving the services Covered by this provision in the long-term care facility that serves as the Member's primary residence if the following conditions apply: • The facility is willing and able to provide the Covered Service to the Member; • The facility and its Providers meet the requisite licensing and training standards required under Arkansas law; • The facility is certified through Medicare; and • The facility and its Providers agree to abide by the terms and conditions of the Plan's contracts with similar Providers, abide by patient protection standards and requirements imposed by state and federal law, and meet the quality standards of the Plan for similar Providers. The services Covered under this provision include, but are not limited to, skilled nursing care, rehabilitative and other therapy services, and post-acute care, as needed. The Plan may utilize Participating Providers to deliver the services Covered under this provision in the Member's resident facility.	Prior Authorization required.

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Skilled Nursing Facility Services	Coverage is provided for Confinement (on a Semi-private Accommodations basis) and medical services and supplies provided under the direction of a Your Physician in a Skilled Nursing Facility. Health Services rendered in a Skilled Nursing Facility are Covered only for the care and treatment of an Injury or Illness which cannot be safely provided in an outpatient setting, as determined by the Plan.	Prior Authorization required. **Limitations:** Coverage in a Skilled Nursing Facility is subject to a calendar year/Contract Year limitation and medical necessity, as specified in the Schedule of Benefits. Certain Health Services (e.g. lab, x-ray, physical therapy, etc.) rendered during a Member's Confinement are subject to separate benefit restrictions and/or Copayments described elsewhere in this COC or in the Schedule of Benefits.
Surgical Services	Surgical services and other related medical care ordered by and provided by or under the direction of a Your Physician in a Hospital, Participating SNF or Alternate Facility are Covered.	Prior Authorization required. For oral surgery services, see Dental.
Termination of Pregnancy	Termination of pregnancy after the first trimester is Covered Service only if the life or physical health of the mother or fetus would be endangered if the fetus were carried to term, or if fetal abnormalities incompatible with life are detected. Not a covered service for Individual	Prior Authorization required.

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Transplants	Services related to Medically Necessary organ transplants are Covered when approved by the Plan and performed at a Coventry Transplant Network facility approved by the Plan. Donor screening tests are Covered and are subject to a Lifetime benefit maximum of [$10,000-$20,000]. Coverage shall include the treatment of breast cancer by autologous bone marrow transplants or stem cell transplants when performed pursuant to nationally accepted peer review protocols utilized by breast cancer treatment centers experienced in autologous bone marrow transplants or stem cell transplants. Coverage for human leukocyte antigen (HLA) testing for bone marrow transplantation is included once per Lifetime. Reimbursement shall be no greater than seventy-five ($75) dollars and the Member must sign an informed consent which authorizes the results of the test to be used for participation in the National Marrow Donor Program.	A separate authorization is required for each phase of the transplant. **Limitations:** There is no Coverage under the Plan's guidelines for transplantation Health Services for the donor under this Plan if the recipient is not a Member. However, if the recipient is a Member, then Health Services and supplies necessary for harvesting for a Covered transplant will be Covered. Coverage for immunosuppressant drugs will be provided under the Member's pharmacy Rider (if purchased). **Exclusions:** Services received at a non-Coventry Transplant Network Facility will not be Covered. Bone marrow and stem cell Transplants unless Covered by a Supplemental Rider. Any transplant service deemed Experimental or Investigational will not be Covered.

COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY THE PLAN TO BE MEDICALLY NECESSARY		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**AUTHORIZATION REQUIREMENTS, LIMITATIONS, AND EXCLUSIONS**
Urgent Care Services	Coverage is provided for Urgent Care Services provided at an Alternate Facility such as an urgent care center or after hours facility.	
Well Child Care, Including Physician Hospital Visits for Newborns	Physician Hospital visits for eligible newborn babies are Covered up to thirty-one (31) days after birth. See Newborn Care in this section. Also included are periodic reviews of a child's physical and emotional status by or under the supervision of Your Provider. Newborns, infants, and children become eligible for these reviews pursuant to the Plan's criteria, which is based on national standards, as defined by the Guide to Clinical Preventative Services, Report of the United States Preventative Services Task Force. See ”Immunizations” in this section for information about child immunizations.	

SECTION 7
OUT OF THE SERVICE AREA

7.1 Confinement in non-Participating Hospital or Hospital Out of Service Area

If the Member is Confined to a Hospital, that Member is required to contact the Plan by calling the number listed either in the Schedule Of Important Telephone Numbers And Addresses, or on the back of the Member's ID card, or arrange for another person to contact the Plan within forty-eight (48) hours from the time the Member seeks treatment for the condition, or as soon as it is reasonably possible. Contact the Plan for information about the Plan's guidelines on transplantation Health Services. You may request a listing of Coventry Transplant Network Facilities from the Member Services Department. This listing may be amended from time to time.

7.2 Basic Health Services Rendered Out of Service Area

For purposes of this section, "Basic Health Services" shall mean those services that could reasonably have been foreseen prior to a Member's departure from the Service Area. If the Member receives Basic Health Services out of the Service Area including, but not limited to, maternity services, immunizations, hemodialysis, and scheduled laboratory tests, such Basic Health Services will be Covered at the lower Out-of-Network benefit level. In addition, if a Member travels outside of the Service Area for the purpose of obtaining medical services, those services will not be Covered at the In-Network Benefit Level, even if they might otherwise qualify as Emergency Health Services, unless such service was Authorized in advance by the Plan. Please remember that only those Providers listed in the Provider Directory qualify as Participating Providers

7.3 Emergency for Out of Service Area

When an Emergency occurs outside the Service Area, a Member should seek medical attention immediately from a Hospital, Physician's office or other Emergency facility. The Plan will provide Coverage at the In-Network benefit level for an Emergency that occurs when the Member is temporarily out of the Service Area under the following conditions:

- The Member's medical condition does not permit the Member's return to the Service Area for treatment; and

- The reason for being outside the Service Area is for some purpose other than the receipt of treatment for a non-Authorized, medical condition.

When this occurs, services will be Covered until the medical condition permits travel or transport back to the Service Area. The Member must notify the Plan within forty-eight (48) hours of the onset of the Emergency, or within a reasonable period as dictated by the circumstances. At the request of the Plan, You must make

available full details of the Emergency Health Services received. Services provided by an Emergency facility for non-Medical Emergencies are not Covered.

A Member may be transported from outside the Service Area to the Service Area or from a Hospital not affiliated with the Plan to a Participating Provider for continued medical management of an Emergency condition. If the non-Participating Hospital determines that the Member is stabilized, the Hospital and Medical Director (or Medical Director's designee) may confer regarding a decision to transfer the Member to a Participating facility. Air or ground ambulance transportation to return a Member to a Participating Provider is Covered when Authorized by the Plan. If You remain in a non-Participating facility after the Plan has made the appropriate arrangements for transfer to a Participating facility, services rendered by Non-Participating Providers or in non-Participating facilities will not be Covered at the In-Network level of benefits.

IF MEDICALLY NECESSARY FOLLOW-UP CARE RELATED TO THE INITIAL MEDICAL EMERGENCY IS REQUIRED, PLEASE CONTACT YOUR PHYSICIAN. YOU MUST OBTAIN PRIOR AUTHORIZATION TO BE ELIGIBLE FOR THE IN-NETWORK LEVEL OF BENEFITS Follow-up care for Medical Emergency services must be provided, Authorized or referred by Your Physician in conjunction with the Plan. Follow-up care is defined as Medical Necessary treatment related to and rendered within, seventy-two (72) hours of the initial Emergency.

The Plan does not cover at the In-Network benefit level, services and supplies required for treatment which You reasonably could have foreseen prior to Your departure from the Service Area.

SECTION 8
EXCLUSIONS AND LIMITATIONS

The following items are excluded from Coverage both In-Network and Out-of-Network:

1) Any service or supply that is not Medically Necessary;

2) Any service or supply that is not a Covered service or that is directly or indirectly a result of receiving a non-Covered Service;

3) Any service or supply for which You have no financial liability or that was provided at no charge; those Health Services for which the Member has no legal obligation to pay or for which a charge would not ordinarily be made in the absence of Coverage under the Agreement;

4) Procedures and treatments that the Plan determines to be Experimental or Investigational as defined in Section 1.36;

5) Court-ordered services or services that are a condition of probation or parole;

6) Those Health Services otherwise Covered under the Agreement related to a specific condition when a Member has refused to comply with, or has terminated the scheduled service or treatment against the advice of a Your Provider or the Mental Health/Substance Abuse Designee;

7) Those Health Services otherwise Covered under the Agreement, but rendered after the date individual Coverage under the Agreement terminates, including Health Services for medical conditions arising prior to the date individual Coverage under the Agreement terminates; and

8) Those Health Services rendered outside the scope of a Participating or Non-Participating Provider's license, rendered by a Provider with the same legal residence as a Member, or rendered by a person who is a member of a Member's family, including spouse, brother, sister, parent, step-parent, child or step-child.

9) Health Services for Dependents of a Dependent are excluded except if (a) included specifically by as set forth in Section 3.1 “Dependent Eligibility”.

Specifically excluded services include, but are not limited to, the following:

1) Abortion - Elective Abortion;

2) Acupuncture - Those acupuncture services and associated expenses which include, but are not limited to, the treatment of certain painful conditions or for anesthesia purposes;

3) Allergy Services - Those non-Physician allergy services or associated expenses relating to an allergic condition including, but not limited to, installation of air filters, air purifiers, or air ventilation system cleaning;

4) Alternative Therapies - Alternative therapies, including, but not limited to, recreational, educational, music or sleep therapies and any related diagnostic testing, massage

5) Ambulance Service - Ambulance transportation due to the absence of other transportation on the part of the Member is excluded. Non Medical Emergency ambulance services are excluded regardless of who requested the services;

6) Augmentative Communication Devices, including but not limited to devices utilizing word processing software and voice recognition software;

7) Autopsy - Those services and associated expenses related to the performance of autopsies to the extent that payment for such services is, by law, covered by any governmental agency as a primary plan;

8) Behavior modification - Those behavioral or educational disorder services and associated expenses related to confirmation of diagnosis, progress, staging or treatment of behavioral (conduct) problems, ADD, Oppositional Defiant Disorder, learning disabilities, developmental delays, mental retardation, anoxic birth injuries, birth defects, cerebral Injury, non-acute head injuries, or cerebral palsy;

9) Biofeedback;

10) Blood Storage - Those services and associated expenses related to personal blood storage, unless associated with a scheduled surgery. Additionally, fetal cord blood harvesting and storage is not a Covered service;

11) Braces and supports needed for athletic participation or employment;

12) Care rendered to You by a relative;

13) Charges resulting from Your failure to appropriately cancel a scheduled appointment;

14) Christian Science Practitioners - Christian Science Practitioners' services are excluded with the exception of the Medicare certified Religious Non Medical Health Care Institutions (RNHCIs) Services. The services and supplies provided by a naturopath are also excluded;

15) Cochlear Implants and related services;

16) Cosmetic Services and Surgery - Those Health Services, associated expenses, or complications resulting from Cosmetic Surgery are not Covered. Cosmetic procedures include, but are not limited to, pharmacological regimens, plastic surgery, blepharoplasty, and non-Medically Necessary dermatological procedures and Reconstructive Surgery. Cosmetic procedures are those procedures that improve physical appearance, but do not correct or materially

improve a patho-physiological function and are not Medically Necessary except when the procedure is needed for prompt repair of accidental Injury or significantly improve the function of a congenital anomaly. Breast reconstruction following a Medically Necessary mastectomy is not considered Cosmetic and is a Covered Service;

17) Counseling- Services and treatment related to religious counseling, marital/relationship counseling, vocational or employment counseling, and sex therapy are not Covered Services;

18) Custodial Care, domiciliary care, private duty nursing, respite care or rest care. This includes care that assists Members in the activities of daily living like walking, getting in and out of bed, bathing, dressing, feeding and using the toilet; preparation of special diets and supervision of medication that is usually self-administered. Custodial Care also includes any health-related services that do not seek to cure, are provided during periods when the medical condition of the patient is not changing or that do not require continued administration by trained medical personnel;

19) Dental Services - Those dental services provided by a Doctor of Dental Surgery, "D.D.S.," a Doctor of Medical Dentistry "D.M.D." or a Physician licensed to perform dental related oral surgical procedures (including services for overbite or underbite,) whether the services are considered to be medical or dental in nature except as provided in Section 6 "Covered Services" of this COC. Dental x-rays, supplies and appliances (including occlusal splints and orthodontia The diagnosis and treatment for temporomandibular joint disease (TMJ) and craniomandibular joint disease is not Covered unless by an attached Rider. Removal of dentiginous cysts, mandibular tori and odontiod cysts are excluded as they are dental in origin;

20) Dental Surgery and Implants - Dental implants are excluded. Removal of dentiginous cysts, mandibular tori, and odontoid cysts are excluded as they are dental in origin. Removal of teeth as a complication of radionecrosis or to prevent systemic infection is not a Covered Service;

21) Durable Medical Equipment ("DME"), Repairs or Replacement - Those repairs or replacement costs for any otherwise Covered DME; maintenance due to normal wear and tear of items owned by the Member; personal comfort items including, but not limited to air conditioners, humidifiers and dehumidifiers, bathtub assistive devices, wheelchair lifts; athletic equipment. There is also no Coverage for the equipment, device, or appliance if the Member is non-compliant with its' use as prescribed by the Member's Physician.

22) Educational Services - Those services for remedial education including, but not limited to, evaluation or treatment of learning disabilities, minimal brain dysfunction, cerebral palsy, mental retardation, developmental and learning disorders and behavioral training;

23) Equipment or services for use in altering air quality or temperature;

24) Educational testing or psychological testing, unless part of a treatment program for Covered services;

25) Elective or Voluntary Enhancement- Elective or voluntary enhancement procedures, services, and medications (growth hormone and testosterone), including, but not limited to: weight loss, hair growth, sexual performance, athletic performance, Cosmetic purposes, anti-aging, mental performance, salabrasion, chemosurgery, laser surgery or other skin abrasion procedures associated with the removal of scars, tattoos, or actinic changes. In addition, service performed for the treatment of acne, even when the medical or surgical treatment has been provided by the Plan for the condition resulting in the scar, are not Covered;

26) Eligible Expenses - Any otherwise Eligible Expenses that exceed the maximum allowance or benefit limit;

27) Enteral Feeding Food Supplement - The cost of outpatient enteral tube feedings or formula and supplies except when used for Phenylketonuria (PKU) or any other amino and organic acid inherited disease is not Covered, except as defined as a Covered Service;

28) Examinations- Those physical, psychiatric or psychological examinations or testing, vaccinations, immunizations or treatments when such services are for purposes of obtaining, maintaining or otherwise relating to career, camp, sports, education, travel, employment, insurance, marriage or adoption. Also excluded are services relating to judicial or administrative proceedings or orders or which are conducted for purposes of medical research or to obtain or maintain a license of any type;

29) Experimental Services - Those Health Services, associated expenses, or complications resulting from Experimental, Investigational, controversial, or unproven Services, treatments, devices and pharmacological regimens, including, but not limited to methadone treatment. The fact that an Experimental, Investigational or unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be Experimental, Investigational or unproven in the treatment of that particular condition. Also excluded are those Health Services and associated expenses for clinical trials that are not deemed to be automatically qualified to receive Medicare coverage except as applicable to state law;

30) Exercise equipment;

31) Eye Glasses and Contact Lenses - Those charges incurred in connection with the provision or fitting of eye glasses or contact lenses, except for initial placement immediately after cataract surgery;

32) Eye Services - Those Health Services and associated expenses for orthoptics, eye exercises, blepharoplasty, radial keratotomy, LASIK and other refractive eye surgery;

33) Food or food supplements;

34) Foot Care - Foot care in connection with corns, calluses, flat feet, fallen arches or chronic foot strain. Medical or surgical treatment of onychomycosis (nail fungus). Nail debridement and clipping (except diabetic members) is also excluded;

35) Growth Hormone – Growth hormone therapy for any condition, except in children less than 18 years of age which have been appropriately diagnosed to have a documented growth hormone deficiency. However, this exclusion does not apply to growth hormone therapy for the treatment of Turner's Syndrome or to HIV wasting syndrome;

36) Hair analysis, wigs, and hair transplants – Those services related to the analysis of hair unless used as a diagnostic tool to determine poisoning. Also excluded are hairstyling, wigs, hairpieces and hair prostheses;

37) Health and Athletic Club Membership Equipment – Any cost of enrollment in a health, athletic or similar club is not Covered;

38) Hearing Services and Supplies Those services and associated expenses for cochlear implants, hearing therapy and any related diagnostic hearing tests except as provided in Section 6 (Covered Services) or attached Rider;

39) Home services to help meet personal, family, or domestic needs;

40) Household Equipment and Fixtures- Purchase or rental of household equipment, such as, but not limited to, fitness equipment, air purifiers, central or unit air conditioners, humidifiers, dehumidifiers, water purifiers, hypo-allergenic pillows, power assist chairs, mattresses or waterbeds and electronic communication devices;

41) Hypnotherapy is not Covered;

42) Implant – Health Services and associated expenses for implants are excluded, except as specifically stated in Section 6 "Covered Services" of this COC. There is no Coverage for repair or replacement for any otherwise Covered implant and Health Services related to repair or replacement, except when necessitated due to a change in Member's medical condition. Penile implants for the treatment of impotence having a psychological origin are not Covered. Dental implants are not Covered;

43) Immunizations for travel or employment;

44) Infertility Services - Those Health Services and associated expenses for the treatment of Infertility including, but not limited to, artificial insemination, ICSI (intracytoplasmic sperm injection), or in vivo fertilization, gamete intrafallopian transfer (GIFT) procedures, zygote intrafallopian transfer (ZIFT) procedures, embryo transport, reversal of voluntary sterilization, surrogate parenting, selective reduction, cryo preservation, travel costs, donor eggs or semen and related costs including collection and preparation, non-Medically Necessary amniocentesis, and any Infertility treatment deemed

Experimental or Investigational. Additionally, pharmaceutical agents used for the purpose of treating Infertility are not Covered, unless Covered by a Rider;

45) Lesions – The removal or destruction of skin tags are not Covered. Benign pigmented nevi, sebaceous cysts and seborrheic keratosis that cause no functional impairment;

46) Maintenance Therapy - There is no Coverage for Maintenance Therapy;

47) Maternity care, including term, premature labor and delivery, cesarean sections, abortions, and prenatal and postnatal services. Complications of pregnancy however are covered.

48) Medical Record Costs

49) Medical Complications – Complications arising directly or indirectly from a non-Covered Service;

50) Military Health Services – Those Health Services for treatment of military service-related disabilities when the Member is legally entitled to other Coverage and for which facilities are reasonably available to the Member; or those Health Services for any otherwise Eligible Employee or Dependent who is on active military duty except as required by the Uniformed Services Employment and Reemployment Rights Act; or Health Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country;

51) Miscellaneous Service Charges - Telephone consultations, charges for failure to keep a scheduled appointment or any late payment charge;

52) Nanometrics – There is no Coverage for Nanometrics implants;

53) No legal obligation to pay - Services are excluded for Injuries and Illnesses for which the Plan has no legal obligation to pay (e.g., free clinics, free government programs, court-ordered care, expenses for which a voluntary contribution is requested) or for that portion of any charge which would not be made but for the availability of benefits from the Plan, or for work-related injuries and Illness. Health Services and supplies furnished under, or as part of a study, grant, or research program are excluded;

54) Non-Prescription Drugs – Over-the-counter drugs and medications incidental to outpatient care and Urgent Care Services are excluded. Take home drugs and medications resulting from an Emergency visit or Hospital stay are Covered;

55) Nutritional-based Therapy – Nutritional-based therapies except for treatment of phenylketonuria (PKU) and for nutritional deficiencies due to short bowel syndrome and HIV. Oral supplements and/or enteral feedings, either by mouth or by tube, are also excluded;

56) Obesity Services - Those Health Services and associated expenses for procedures intended primarily for the treatment of obesity and morbid

obesity including, but not limited to, gastric bypasses, gastric balloons, stomach stapling, jejunal bypasses, wiring of the jaw, removal of excess skin, including pannus, and Health Services of a similar nature are not Covered. Health Services and associated expenses for weight loss programs, nutritional supplements, appetite suppressants, and supplies of a similar nature are not Covered;

57) Occupational Injury- Those Health Services and associated expenses related to the treatment of an Occupational Injury or Illness for which the Member is eligible to receive treatment under any Workers' Compensation or Occupational disease laws or benefit plans;

58) Oral Surgery Supplies – Those supplies required as part of an orthodontic treatment program, required for correction of an occlusal defect, encompassing orthoganathic or prognathic surgical procedures, or removal of symptomatic bony impacted teeth;

59) Orthodontia and related services;

60) Orthotic Appliances and Prosthetic Devices and Repairs – No Coverage is provided for repair, or duplicates nor is Coverage provided for Health Services related to any repair. Over the counter braces, splints and Orthotics are not Covered. Advanced versions of devices are not Covered. Orthopedic shoes are not Covered. Cranial helmets are not Covered, unless the congenital defect of the skull adversely effects normal brain, auditory, visual or central nervous system development. Shoe inserts are not Covered unless the Member has diabetes with demonstrated peripheral neuropathy or the insert is needed for a shoe that is part of a brace;

61) Other Coverage Services – Those Health Services for which other Coverage is required by federal, state, or local law to be purchased or provided through other arrangements, including, but not limited to, Coverage required by workers' compensation, no-fault automobile insurance or other similar legislation;

62) Over-the-counter supplies such as ACE wraps, elastic supports, finger splints, Orthotics, and braces;

63) Personal Comfort - Those personal comfort and convenience items or services such as television, telephone, barber or beauty service, guest service and similar incidental services and supplies;

64) Physical, Psychiatric, or Psychological Examinations or Testing, Etc. - Those physical, psychiatric, neuropsychological, or psychological examinations or testing, or vaccinations, immunizations, or treatments and associated expenses, when such services are for purposes of obtaining, maintaining or otherwise related to education, employment, insurance, travel, marriage or adoption, senile dementia and Alzheimer's, or relating to judicial or administrative proceeds or orders, or which are conducted for purposes of medical research, or to obtain or maintain a license or official document of any type;

65) Prescription Medication - Those prescription medications for outpatient treatment, except as Covered under a Prescription Rider to the Agreement. Specifically excluded from Coverage are:

- Non-prescription contraceptive devices (e.g., condoms, spermicidal agents);
- Any outpatient prescription drug which is to be administered, in whole or in part, while a Member is in a Hospital, medical office or other health care facility;
- Compounded prescriptions whose ingredients do not require a prescription;
- Cost for packaging required for drugs dispensed in nursing homes;
- Dietary supplements, appetite suppressants, and other drugs used to treat obesity or assist in weight reduction;
- Drugs and products for smoking cessation (e.g., Nicorette gum and smoking cessation skin patches);
- Drugs and products used for Cosmetic purposes;
- Drugs and products used for fertility;
- Drugs and products used to enhance athletic performance including testosterone gel, and growth hormones;
- Drugs used primarily for hair restoration;
- Experimental products, or drugs prescribed for Experimental indications, including those labeled “Caution – Limited by Federal Law to Investigational Use”;
- Injectable and self-injectable medications, except those designated by the Plan;
- Over-the-counter (OTC) products not requiring a prescription to be dispensed (e.g., aspirin, antacids, herbal products, oxygen, medicated soaps, food supplements, and bandages);
- Legend drugs for which there is a non-Prescription Drug alternative (e.g., OTC);
- Prescription Drugs related to a non-Covered Service;

- Products not approved by the FDA, medications with no FDA approved indications;
- Vitamins and minerals (both OTC and legend), except legend prenatal vitamins for pregnant or nursing females, liquid or chewable legend pediatric vitamins for children;
- Prescription Medications taken for travel;
- Replacement prescriptions resulting from loss or theft;
- Any non-FDA approved medication usage, including, but not limited to medical condition, dosage, age limitations, or route of administration;

66) Private Duty Nursing - Private duty nursing services, nursing care on a full-time basis in Your home, or home health aides;

67) Private inpatient room, unless Medically Necessary or if a Semi-private room is unavailable;

68) Radial keratotomy, LASIK, and blepharoplasty;

69) Reduction or Augmentation Mammoplasty - Reduction or augmentation mammoplasty is excluded unless associated with Reconstructive Surgery following a Medically Necessary mastectomy. Breast reduction for male physiologic gynecomastia is also excluded;

70) Rehabilitative Services – Maintenance therapy and those rehabilitative services and associated expenses which are not short-term rehabilitative services;

71) Robotics;

72) Sex Transformation Services – Health Services and associated expenses for sex transformation operations regardless of any diagnosis of gender role disorientation or psychosexual orientation, including any treatment or studies related to sex transformation. Also excluded is hormonal support for sex transformation;

73) Sexual Dysfunction – Self-administered prescription medication and penile prostheses for the treatment of sexual dysfunction, including erectile dysfunction, impotence and anorgasmy;

74) Skin Abrasion, Etc. - Salabrasion, chemosurgery, laser surgery or other such skin abrasion procedures associated with the removal of scars, tattoos, actinic changes and/or which are performed as a treatment for acne even when the medical or surgical treatment has been provided by the Plan for the condition resulting in the scar;

75) Skin tags;

76) Smoking Cessation Those services and supplies for smoking cessation programs and treatment of nicotine addiction;

77) Speech Therapy - Health Services for the diagnosis and treatment of chronic brain Injury, including augmentative communication devices, developmental delay, mental retardation or cerebral palsy are not Covered, except as provided in Section 6 (Covered Services) or attached Rider ;

78) Sports Related Services – Those services or devices used specifically as safety items or to affect performance primarily in sports-related activities, and all expenses related to physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation; personal trainers; braces and Orthotics (including protective braces and devices);

79) Sterilization Services – Those Health Services and associated expenses related to voluntary sterilizations and the reversal of voluntary sterilizations;

80) Surgery performed solely to address psychological or emotional factors;

81) Surrogate motherhood services and supplies, including, but not limited to, all services and supplies relating to the conception and pregnancy of a Member acting as a surrogate mother;

82) Syringes - Disposable syringes (except for insulin syringes);

83) Third Party Liability - Services for which a third party has liability are excluded, including services Covered by federal, state, and other laws, except as they may apply to federal and state medical assistance programs;

84) Transplant Organ Removal – Those Health Services and associated expenses for removal of an organ for the purposes or transplantation from a donor who is not a Member unless the recipient is a Member and the donor's medical Coverage excludes reimbursement for organ harvesting. Also excluded are Health Services and associated expenses for transplants involving mechanical or animal organs;

85) Transplant services, screening tests, and any related conditions or complications related to organ donation when a Member is donating organ or tissue to a non-Covered individual;

86) Travel Expenses - Travel or transportation expenses, except ambulance service as specifically described in this Plan, even though prescribed by a Participating Provider, except as specified in Section 6;

87) Treatment for disorders relating to learning, motor skills, communication, and pervasive developmental conditions such as, cerebral palsy and ADD;

88) Vericose Veins;

89) Vision Aids, Associated Services - Expenses incurred for eyeglasses, lenses or frames; fitting of lenses or frames; orthoptics or vision training; biomicroscopy; field charting or aniseikonia investigation; devices to correct

vision; LASIK, radial keratotomy low vision aids and services or other refractive surgery; any service or material not provided by the Plan's Designated Vision Provider, except as provided in a Vision Rider;

90) Vision care and optometry services, except as provided in Section 6;

91) Vocational therapy;

92) War related Illness, Injury, services or care for military services-connected disabilities and conditions for which You are legally entitled to Veteran's Administration services and for which facilities are reasonably accessible to You;

93) Health Services resulting from war or an act of war;

94) Work hardening programs;

95) Workers' Compensation Health Services - Payment for services or supplies for an Illness or Injury eligible for, or Covered by, any Federal, State or local Government Workers' Compensation Act, Occupational Disease law or other legislation of similar purpose, unless the employer is not required by law to provide such coverage;

The following limitations apply:

96) Any services, Hospital, professional or otherwise that are not performed by a Participating Provider will be covered at the Out-of-Network benefit level. This limitation shall not apply for Medical Emergencies or Urgent Care Services rendered at an urgent care center or after hour's facility. In the event that specific Health Services cannot be provided by or through a Participating Provider, You may be eligible for Coverage of Eligible Expenses at the In-Network level for Medically Necessary Health Services obtained through non-Participating Providers if Authorized in advance through the Plan.

97) Benefits will be reduced as follows when a Member does not participate in our Utilization Management Program:

    If a Member elects not to request Prior Authorization and Continued Stay Review for inpatient Hospital services or fails to act within the required time limits, a $1,000 penalty will be assessed. Any penalty is not applicable to the Out of-Pocket Maximum.

    If other services which require Prior Authorization as stipulated in Section 2.3 are performed without a Prior Authorization, Coverage of those Covered Services will be reduced by 20%, subject to any applicable Deductible and Coinsurance. Any payment due to a reduction of benefits does not apply to the Out-of-Pocket Maximum. Any Deductible will be applied prior to a reduction in benefits.

SECTION 9
CLAIMS AND REIMBURSEMENT

9.1 Participating Provider Expenses

Participating Providers are responsible for submitting a claim form for Eligible Expenses for each Health Service and may not bill Members for Health Services except for applicable Copayments, Coinsurance, Annual Deductibles, and non-Covered Services. In the event a Member is billed by a Participating Provider for Covered Eligible Expenses, the Member should contact the Plan at the telephone number listed on the Schedule of Important Numbers in this Certificate and on the back of Your identification card.

9.2 Notice of Claim.

For services received from Non-Participating Providers that are Covered under the Policy, and for services Covered as at the Out-of-Network benefit level, claims for reimbursement must be submitted in accordance with the procedure set forth in this Section 9.

Written notice must be given to the Plan within twenty (20) days after the occurrence or commencement of any loss covered under the Policy. Failure to give notice within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as reasonably possible.

The Plan shall furnish to the person-making claim, or to the policyholder for delivery to such person, such forms as are usually furnished by it for filing proof of loss. If such forms are not furnished before the expiration of fifteen (15) days after the Plan received notice of any claim under the policy, the person making such claims shall be deemed to have complied with the requirements of the policy as to proof of loss upon submitting, within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, character and extent of the loss for which claim is made.

Written proof of loss (i.e. cancelled check, credit card statement) and a completed claim form must be submitted to the Plan within ninety (90) days of the date of the loss. The claim form itself may qualify as proof of loss if the bill has not been paid prior to the filing of the claim. Failure to furnish such proof within the ninety (90) days shall not invalidate nor reduce any claim if it was not reasonably possible to furnish such proof within the ninety (90) days, provided such proof is furnished as soon as is reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one (1) year from the time proof is otherwise required.

All benefits payable under the policy shall be payable not more than thirty (30) days after receipt of proof that is subject to due proof of loss, and that subject to that proof of loss, all benefits payable under the certificate shall be paid as soon as possible after receipt of such proof.

9.3 Section Timing

The Plan may accept a late claim if extenuating circumstances prevent the Member from making a claim during the ninety (90) day period. Each Member shall file with the Plan all pertinent information concerning himself or herself as the Plan may require and in the manner and form as the Plan specifies. The Member shall not have any rights or be entitled to benefits unless he or she files the required information. Each Member claiming benefits under the Plan shall supply written proof that Eligible Expenses were incurred or that the benefit is Covered under the Plan. Examples of acceptable proof of loss include a copy of a cancelled check, or a credit card statement. Claim forms may be obtained from the Plan by calling the telephone number listed on the back of Your identification card. If the Plan determines that a Member has not incurred a Covered expense or that the benefit is not Covered under the Plan or if the Member fails to furnish the requested proof, no reimbursement shall be made to the Member.

In the event of a question or dispute concerning Coverage for Health Services, the Plan may reasonably require that a Member be examined at the Plan's expense by a Physician designated by the Plan during the pendency of a claim and to make an autopsy in the case of death where it is not forbidden by law.

No action at law or in equity shall be brought to recover on the policy prior to the expiration of sixty (60) days after proof of loss has been filed and no action shall be brought at all unless brought within three (3) years from the expiration of the time within which proof of loss is required by the Policy.

9.4 Reinstatement

In the event that the Plan terminates Your Coverage due to non-payment of Premiums, You may apply for reinstatement within sixty (60) days of termination, but You and any of Your Eligible Dependents will be subject to Medical Underwriting. A new evaluation of Your (and Your Dependents') medical history will determine the Plan's approval of Your reinstatement enrollment request and Your final Premium rates for Coverage.

The Plan will notify You when Your application for reinstatement has been accepted. Your enrollment has not been reinstated unless and until You receive such notice. Such acceptance renders all terms and conditions of the Contract binding on the Plan, the Subscriber and any Dependent Members. Coverage shall become effective upon payment of applicable Premiums. Pre-existing Condition Exclusions may apply as explained in Section 1.76.

The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more that ten (10) days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted Premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any Premium accepted in connection with a reinstatement shall be applied to a period for which Premium has not been previously paid, but not to any period more than sixty (60) days prior to the date or reinstatement.

9.5 Payment to Public Entities

Any benefits payable hereunder to an insured Member shall be payable with or without assignment from the insured to a public Hospital or clinic for services or supplies provided to the insured if a proper claim is submitted by the public Hospital or clinic. Payment to the public Hospital or clinic shall discharge the Plan from any and all obligations and liability to the Member to the extent of the benefits paid. In the event the Plan has already made payment on such charges to the insured prior to receipt of the claim from the public Hospital or clinic, the Plan will not be required to pay the claim to the public Hospital or clinic again.

All other benefits of the policy shall be payable to the person insured.

SECTION 10
RESOLVING COMPLAINTS AND GRIEVANCES
Procedures

10.1 Complaints and Inquiries

10.1.1 Investigation Upon Receipt of a Complaint or Inquiry by Telephone: If You have a Complaint or Inquiry, You may submit it by telephone. (See the attached Schedule of Important Telephone Numbers and Addresses.) When this is done, the Member Services representative will make every effort to resolve the issue within one (1) working day. In some cases, however, it may take as long as fifteen (15) working days or more from the date of the call for resolution.

10.1.2 Written Inquiries: You may submit a written Inquiry to the Member Services Department. (See the attached Schedule of Important Telephone Numbers and Addresses.) You will be sent an acknowledgement letter within three (3) working days of the original receipt of the Inquiry. When this is done, you will receive resolution of the Inquiry within thirty (30) calendar days.

10.1.3 Written Complaints: You may submit a Complaint in writing to the Member Services Department. (See the attached Schedule of Important Telephone Numbers and Addresses.) You will be sent an acknowledgement letter within ten (10) working days of the original receipt of the Complaint. The investigation of the Complaint will be completed within twenty (20) working days of original receipt of the Complaint unless you receive notice from the Plan that additional time is required. Within five (5) working days after the completion of the investigation, You and Your Authorized Representative will be notified of the resolution of the Complaint.

10.2 Appeals

10.2.1 Notice of Appeal: If You wish to submit an Appeal, You should contact Member Services in writing. If You prefer, You may also request information by contacting Member Services by telephone. (See the attached Schedule of Important Telephone Numbers and Addresses.) However, a formal Appeal must be submitted in writing and must include the following information:

- Member name;
- Provider name;
- Date(s) of service;
- Member's and/or Member's Authorized Representative's mailing address;
- Clear indication of the remedy or corrective action being sought and an explanation of why the Plan should "reverse" the Adverse Benefit Determination;
- Copy of documentation to support the reversal of decision, e.g. Emergency details, date, time, symptoms, why the Member did not contact the PCP, etc.; and
- In cases where the Member's Authorized Representative is appealing on behalf of the member, a completed Member Designated Release of Information form, which can be obtained by calling the Member Services Department

Requesting information by telephone does not constitute filing an Appeal.

10.2.2 Pre-Service Appeal Review: A pre-service Appeal may be requested by You or Your Authorized Representative but must be submitted in writing within 180 days of an Adverse Benefit Determination.

Within thirty (30) calendar days after the receipt of the Appeal, the Plan will notify You and Your Authorized Representative in writing of the Plan's decision regarding the Appeal and of Your right to file an Appeal for a second-level review.

10.2.3 Post-Service Appeal Review: A Post-Service Appeal may be requested by You or Your Authorized Representative but must be submitted in writing within 180 days of an Adverse Benefit Determination.

Within sixty (60) calendar days after the receipt of the Appeal, the Plan will notify You and Your Authorized Representative in writing of the Plan's decision regarding the Appeal and of Your right to file an Appeal for a second-level review.

10.2.4 Urgent Care Appeal Review: An Urgent Care Appeal may be requested by You or Your Authorized Representative but must be submitted in writing within 180 days of an Adverse Benefit Determination. For Appeals satisfying the definition of an Urgent Care Appeal you may request an expedited Appeal of a Plan decision verbally or in writing. Within a reasonable period of time not to exceed seventy-two (72) hours of receiving a valid request for an Urgent Care Appeal, the Plan will verbally notify You of its decision. The Plan will then send a written confirmation

of its decision within the following three (3) working days.

10.2.5 External Review: If You or Your Authorized Representative are not satisfied with the decision of the Plan and have exhausted the internal appeal process, You or Your Authorized Representative may request an external review in writing or via electronic media within sixty (60) days after receipt of the Plan's decision. The Independent Review Organization assigned will be chosen from a list compiled and maintained by the Arkansas Insurance Department.

10.2.5.1 Within five (5) business days after receipt of the request for an external review, You or Your Authorized Representative and treating Physician will be notified in writing whether the request is complete and if the request has been accepted for external review.

- If the request is not complete, the notice will include the information needed to make the request complete. The additional information must be submitted within seven (7) business days following receipt of the notice.

10.2.5.2 Within forty-five (45) calendar days after receipt of the request for an external review, the Independent Review Organization shall provide written notice of its decision to uphold, reverse, or partially uphold or reverse the Adverse Benefit Determination to You or Your Authorized Representative, treating Physician and the Plan.

- If the Independent Review Organization has overturned any portion or all of the Adverse Benefit Determination, the Plan shall immediately approve the Coverage that was the subject of the Adverse Benefit Determination.

10.2.5.3 You or Your Authorized Representative may request an expedited external review. Within seventy-two (72) hours of the request, the Independent Review Organization will make a decision to uphold or reverse the Adverse Benefit Determination and notify You or Your Authorized Representative, the treating Physician and the Plan.

- An expedited external review may not be provided for Adverse Benefit Determinations involving a Retrospective Review.

10.2.5.4 Except in the case of a request for an expedited external review, at the time of filing a request for an external review, You or Your Authorized Representative shall submit to the Independent Review Organization a filing fee of [$25] along with the information and documentation to be used by the Independent Review Organization

conducting the external review.

10.2.5.5 At any time during the external review process and upon receipt of additional information, the Plan may reconsider its Adverse Benefit Determination.

- The external review process will be terminated; and
- The Plan will immediately notify You or Your Authorized Representative, treating Physician and the Independent Review Organization of its decision.

10.2.6 Department of Commerce and Insurance: The Member, Member's Authorized Representative, or a Physician acting on behalf of a Member has the right to contact the Department of Commerce and Insurance at any time in this process. The Department may be contacted at the number listed in the Schedule of Important Numbers.

SECTION 11
CONFIDENTIALITY OF YOUR HEALTH INFORMATION

11.1 Privacy Information

The Plan needs information about You to manage Your benefits. We collect your information from many sources and keeping your information safe is one of our most important jobs. We make sure that only people who need to use Your information have access to it. We may use and share Your information for:

- Treatment
- Payment
- Health care operations

These uses are covered under state and federal laws. Our policies will reflect the most protective laws that apply to You.

Here are some other ways that we may use or share Your personal information:

- To help providers and other health plans in Your treatment, payment and health care operations.
- To give out information if required by law.
- To other businesses who work for us.
- To tell you about treatment options or health related services.
- To help the sponsor of Your health plan serve You.
- To people You have said may receive Your information.
- To those having a relationship that gives them the right to act on Your behalf.
- To researchers who take all required steps to protect Your privacy.

  Other times, we may need to get your permission to use or share Your health information.

11.2 Notice of Privacy Practices

As one of our members, You have certain rights. More information is in the Plan's Notice of Privacy Practices, which You should read. These rights, with some limits, include:

- Asking for restrictions
- Asking for confidential communications
- Asking to see and get copies of Your information

- Asking for corrections to Your information
- Asking for a report of how we may have shared Your information
- Sending a complaint or receiving more information

SECTION 12
GENERAL PROVISIONS

12.1 Applicability

The provisions of this Agreement shall apply equally to the Subscriber and Dependents and all benefits and privileges made available to You shall be available to Your Dependents.

12.2 Governing Law

This Plan is delivered and governed by the laws of the State ofArkansas.

12.3 Limitation of Action

Members are encouraged to exhaust the Plan Complaint and Grievance Procedure prior to pursuing legal action, (in a court or other government tribunal) as this is the most expeditious and cost-effective method of resolving Member concerns.

12.4 Nontransferable

No person other than You is entitled to receive health care service Coverage or other benefits to be furnished by the Plan under this Agreement. Such right to health care service Coverage or other benefits is not transferable.

12.5 Relationship Among Parties Affected by Agreement

The relationship between the Plan and Participating Providers is that of independent contractors. Participating Providers are not agents or employees of the Plan, nor is the Plan or any employee of the Plan an employee or agent of Participating Providers. Participating Providers shall maintain the provider-patient relationship with You and are solely responsible to You for all Participating Provider services.

You are nota agent or representatives of the Plan, and neither shall be liable for any acts or omissions of the Plan for the performance of services under this Agreement.

12.6 Contractual Relationships

The Plan agrees to provide Coverage for Health Services to Members, subject to the terms, conditions, exclusions and limitations of the Agreement. This COC is issued on the basis of the Subscriber's enrollment in the Plans payment to the Plan of the required Premium. The Plan has the right to increase Premium rates, provided the Member if is the Member is given thirty-one (31) days advance written notice.

12.7 Reservations and Alternatives

The Plan reserve the right to contract with other corporations, associations, partnerships, or individuals for the furnishing and rendering of any of the services or benefits described herein. The identity of the service providers and the nature of the services provided may be changed from time to time and without prior notice to or approval by Enrolling Units or Members. You must cooperate with those persons or entities in the performance of their responsibilities.

12.8 Severability

In the event that any provision of this Agreement is held to be invalid or unenforceable for any reason, the invalidity or unenforceability of that provision shall not affect the remainder of this Agreement, which shall continue in full force and effect in accordance with its remaining terms.

12.9 Valid Amendment

No change in this Agreement shall be valid unless approved by an Officer of the Plan, and evidenced by endorsement on this Agreement and/or by Amendment to this Agreement. Such Amendments will be incorporated into this COC. Amendments to the COC are effective upon thirty-one (31) days written notice to the Member. No change will be made to the COC unless made by an Amendment or a Rider that is issued by the Plan. No agent has authority to change the COC or to waive any of its provisions. Copayment changes shall be made only on the anniversary date of Your COC unless by mutual agreement of the Plan and the Enrolling Unit

12.10 Waiver

The failure of the Plan or You to enforce any provision of this Agreement shall not be deemed or construed to be a waiver of the enforceability of such provision. Similarly, the failure to enforce any remedy arising from a default under the terms of this Agreement shall not be deemed or construed to be a waiver of such default.

12.11 Entire Agreement

This Agreement, including the endorsements and attached papers, shall constitute the entire Agreement between the parties. All statements, in the absence of fraud, pertaining to Coverage under this Agreement that are made by You shall be deemed representations, but not warranties. No such statement shall void or reduce under the Agreement or be used in defense of a legal action unless it is contained in a written instrument. Finally, no such statements, except fraudulent statements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred commencing after the expiration of such two (2) year period. After this policy has been in force for a period of two (2) years during the lifetime of the Member (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application.

Notwithstanding the Schedule of Benefits in this Plan, the Plan may provide different benefits to different Enrolling Units or individuals, as determined by the Plan and applicable Enrolling Units or individuals. Such differences in benefits shall be allowed only as the result of a written Amendment to the Agreement or a written Rider or similar document, approved by the Plan. The Enrolling Unit will notify those Members affected by such different benefits.

12.12 Participation in Policies of The Plan

Any Member who wishes to participate in matters of the Plan's policies and operations may do so by submitting suggestions, in writing, to Member Services at the address on the attached Schedule of Important Telephone Numbers and Addresses. The Member Advisory Committee will investigate the viability and appropriateness of the suggestion and recommend approval or disapproval to the Plan's policymaking body, pursuant to Arkansas law.

12.13 Records

The Member shall furnish the Plan with all medical information and proofs of previous coverage that the Plan may reasonably require with regard to any matters pertaining to this COC in the event the Plan is unable to obtain this information directly from the Provider or insurer.

By accepting Coverage under the COC, each Member, including Enrolled Dependents, whether or not such Enrolled Dependents have signed the application of the Subscriber, authorizes and directs any person or institution that has provided services to the Member, to furnish the Plan or any of the Plan' s designees at any reasonable time, upon its request, relevant information and records or copies of records relating to the services provided to the Member. The Plan agrees that such information and records will be considered confidential. Upon the Member’s consent, the Plan and any of the Plan's designees shall have the right to release, and secondarily release any and all records concerning Health Services which are necessary to implement and administer the terms of the COC or for appropriate medical review or quality assessment.

12.14 Examination of Members and Autopsy

Physical Examinations and Autopsy: The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

12.15 Clerical Error

Clerical error shall not deprive any individual of Coverage under the COC or create a right to additional benefits.

12.16 Notice

Written notice given by the Plan to all affected Subscribers and their Enrolled Dependents in the administration of Coverage under the COC.

12.17 Workers' Compensation

The Coverage provided under the COC does not substitute for and does not affect any requirements for Coverage by Workers' Compensation Insurance.

12.18 Conformity with Statutes

Any provision of the COC which, on its Effective Date, is in conflict with the requirements of statutes or regulations of the jurisdiction in which it is delivered, is hereby amended to conform to the minimum requirements of such statutes and regulations.

12.19 Non-Discrimination

In compliance with state and federal law, the Plan shall not discriminate on the basis of age, color, disability, gender, marital status, national origin, religion, sexual preference, or public assistance status.

12.20 Provisions Relating to Medicaid Eligibility

Payment for benefits will be made in accordance with assignment of rights made by or on behalf of a Member, as required by a State plan for medical assistance approved under title XIX of the Social Security Act. To the extent that payment has been made under such State plan in any case in which the Plan has a legal liability under the Plan to make payment for such Health Services, the Plan will pay for such Health Services in accordance with any State law, provided that the State has acquired such rights to payment.

The fact that a person is eligible for or provided medical assistance under a State plan for medical assistance approved under Title XIX of the Social Security Act shall not be taken into account in enrolling such person, or in determining or making benefit payments under the Plan.

12.21 Policies and Procedures

The Plan may adopt policies, procedures, rules and interpretations to promote orderly and efficient administration of this Agreement.

12.22 Discretionary Authority

The Plan has the discretionary authority to interpret the Agreement in order to make eligibility and benefit determinations. The Plan also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under this Agreement. In no way shall this section limit any Member's rights as set forth in the Resolving Complaints and Grievances section or any rights permitted under law.

12.23 Value Added Services

From time to time the Plan may offer to provide Members access to discounts on health care related goods or services. While the Plan has arranged for access to these goods, services and/or third party provider discounts, the third party service providers are liable to the Members for the provision of such goods and/or services. The Plan is not responsible for the provision of such goods and/or services nor is it liable for the failure of the provision of the same. Further, the Plan is not liable to the Members for the negligent provision of such goods and/or services by third party service providers. These discounts are subject to modification or discontinuance without notice.

SECTION 13
UTILIZATION REVIEW POLICY AND PROCEDURES

13.1 Utilization Review Circumstances

Utilization review is performed under the following circumstances:

- Prospective or Pre-Service Review - Conducting utilization review for the purpose of Prior Authorization is called Prospective or Pre-Service Review. Services include, but are not limited to, elective inpatient admission and outpatient surgeries that require Prior Authorization.
- Concurrent Care Review - Review that occurs at the time care is rendered. When You are Hospitalized or Confined to a SNF, concurrent review is conducted on site or by telephone with the utilization review department at each facility.
- Retrospective or Post-Service Review - Retrospective or Post-Service review is utilization review that takes place for medical services that have not been Authorized by the Plan, after the services have been provided. For example, Emergency Room visits are reviewed after they occur.

Toll Free Telephone Number - The toll free telephone number of the utilization review department is listed in the Plan's Schedule of Important Telephone Numbers and Addresses. Voice messages recorded regarding Utilization Review will be returned within two (2) working days.

13.2 Timing Of Utilization Review Decisions

The time-frame for making utilization review decisions is as follows:

- Prospective or Pre-Service Review –

    1. Notification of a determination shall be verbally by mail or within two (2) business days of the receipt of the request and receipt of all information necessary to complete the review.
    2. A determination as to the necessity or appropriateness of an admission, service, or procedure shall be reviewed by a physician or determined in accordance with standards or guidelines approved by a physician.
    3. In the case of an Adverse Benefit Determination, the notice of Adverse Benefit Determination must include the principal reason for the determination and the procedures to initiate an appeal.

- Concurrent Care Review –
    1. Notification of a determination shall be verbally by mail or within two (2) business days of the receipt of the request and receipt of all information necessary to complete the review.

2. A determination as to the necessity or appropriateness of an admission, service, or procedure shall be reviewed by a physician or determined in accordance with standards or guidelines approved by a physician.
3. In the case of an Adverse Benefit Determination, the notice of Adverse Benefit Determination must include the principal reason for the determination and the procedures to initiate an appeal.

- Retrospective or Post-Service Review –

1. Notification of a determination shall be verbally by mail or within two (2) business days of the receipt of the request and receipt of all information necessary to complete the review.
2. A determination as to the necessity or appropriateness of an admission, service, or procedure shall be reviewed by a physician or determined in accordance with standards or guidelines approved by a physician.
3. In the case of an Adverse Benefit Determination, the notice of Adverse Benefit Determination must include the principal reason for the determination and the procedures to initiate an appeal.

13.3 Reconsideration

You have the right to request reconsideration of any adverse determination involving a Prospective or Pre-Service Review as well as any Concurrent Care Review determination. In the case of a Prospective or Concurrent Care Review determination, the attending Physician shall have the right to appeal that determination over the telephone on an expedited basis, if he/she believes that the determination warrants immediate Appeal.

A decision shall occur within forty-eight (48) hours of the date the reconsideration is filed and the receipt of all information necessary to complete the reconsideration.

13.4 Right To Appeal

If the reconsideration process does not resolve the difference of opinion, the Adverse Benefit Determination may be appealed by You or Your Provider on Your behalf though the standard appeal process. Please see the Complaint and Grievance Procedure Section for the time frames for such Appeals. Reconsideration is not a prerequisite to any Appeal.

SUPPLEMENTAL RIDER FOR MENTAL HEALTH BENEFITS

This Rider is underwritten and administered by Coventry Health and Life Insurance Company ("CHL"), issued to You on the Effective Date and made a part of the entire Benefit Agreement to which it is attached. Accordingly, all definitions, provisions, terms, limitations, exclusions and conditions of the Certificate of Coverage (COC) apply to this Rider except to the extent such terms and conditions are explicitly superceded or modified by this Rider.

The benefits provided by this Rider become effective on the date that the You purchased ("Effective Date") this supplemental Rider and expires when Your Coverage under this Rider terminates.

ARTICLE 1. DEFINITIONS

Any capitalized terms used in this Rider and not otherwise defined herein shall have the meaning set forth in Your Policy or Certificate of Coverage.

The following definitions apply to this Rider:

Diagnosis (Diagnostic) (Diagnosed)
The classification of a Mental Health Condition through clinical assessment or laboratory examination.

Diagnostic Manual
The most current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association (APA).

Group Psychotherapy
Application of psychotherapeutic techniques by a licensed Provider to a group, including utilization of interactions of members of the group. Usually six (6) to eight (8) persons are a group, and sessions typically last seventy-five (75) minutes or longer.

Medication Management
Services for pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy. This does not include services that could be billed as a therapy or consultation visit.

Mental Health Condition(s)
Any condition or disorder described and defined by categories listed in the most recent edition of the Diagnostic Standard Manual of the American Psychiatric Association except for Chemical Dependency.

Mental Health Designee
The organization, entity or individual that provides or arranges Covered Mental Health Conditions services under contract to Coventry Health and Life Insurance Co.

Partial Hospitalization
Physician directed intensive or intermediate treatment for less than twenty-four (24) hours, but more than four (4) hours in a day, in a licensed or certified facility or program.

Provider
A licensed Physician specializing in the treatment of Mental Health Conditions, a licensed psychologist, a licensed clinical social worker or a licensed professional counselor. Prescription rights shall apply only to Physicians.

Rehabilitation
Methods and techniques (sometimes termed tertiary prevention) to achieve optimum patient functioning and adjustment and to prevent relapses or recurrence of illness.

Visit(s)
A session in an Outpatient care setting in which the time frame is dependent on specific standard service codes used by the Provider.

ARTICLE 2. ELIGIBLE CHARGES

All In-Network and Out-of-Network Covered Services for Mental Health Conditions must be authorized by the Plan or an affiliate designated by Plan. All In-Network and Out-of-Network Covered Services are available for Medically Necessary and treatable Diagnosed conditions and are subject to the limitations, exclusions and Member payment responsibility as described below. In-Network and Out-of-Network Deductibles, Coinsurance and Copayments for Mental Health Conditions Covered Services apply to the Out-of-Pocket Maximum(s).

Inpatient and Partial Hospitalization

- Mental Health Conditions - In-Network and Out-of-Network benefits for Covered Services related to Mental Health Conditions are provided as described below.

Outpatient Services

- For Mental Health Conditions - Medically Necessary care and treatment, subject to the cost-sharing obligations listed below. Two (2) Group Psychotherapy sessions may be substituted for one (1) Outpatient Visit. Visits for Medication Management are not subject to outpatient visit limitations.

Inpatient and Partial Hospitalization Services: [20-Unlimited] Days	In Network Benefits [$0-$1000 Copayment per admission] [or] [0-50% Coinsurance per admission] [after Deductible] [up to a maximum of $0-$2000] [per calendar year; Contract Year]	[Out of Network Benefits [0% - 50%] of ONR Coinsurance per admission [after Out-of-Network Deductible as listed in the Schedule of Benefits.] [up to a maximum of $0-$2000] [per calendar year; Contract Year] [[$0-$1000] penalty for failure to precertify]]
Outpatient Services: [25-Unlimited] Visits	In Network Benefits [$0-$250 Copayment per Visit] [or] [0-50% Coinsurance per Visit] [after Deductible]	[Out of Network Benefits [0% - 50%] of ONR Coinsurance per Visit [after Out-of-Network Deductible as listed in the Schedule of Benefits.] [[0-20%] penalty for failure to precertify]]

Mental Health Services Benefits

CHL contracts with the Mental Health and Chemical Dependency Designee (**"Designee"**) to coordinate, determine Medical Necessity, and Prior Authorize the Diagnosis and treatment of all Mental Health Conditions and psychiatric conditions. When required, Prior Authorization must be obtained through the contracted Designee. The telephone number for the Behavioral Health Line is listed on the back of Your ID card and in the Directory of Health Care Providers.

Coverage for the treatment of Mental Health Conditions will be the same as Coverage under the medical and surgical benefits for any other illness, condition, or disorder unless otherwise noted.

What is Covered:

1. Outpatient Treatment - Medically Necessary treatment through partial or full-day program services for mental health services for Mental Health Conditions rendered by a licensed professional.

2. Inpatient Treatment - Medically Necessary treatment at a Hospital for Mental Health Conditions.

ARTICLE 3. EXCLUSIONS

The Diagnostic terms in this Article are defined in the Diagnostic Manual. These Exclusions apply under all Inpatient, Partial Hospitalization and Outpatient settings. Diagnosed conditions excluded:

- Marital, family, educational, or training services unless Medically Necessary and clinically appropriate;
- Services rendered or billed by a school or halfway house;
- Care that is custodial in nature;
- Services and supplies that are not immediately nor clinically appropriate; or
- Treatments that are considered experimental.

ARTICLE 4. CONDITIONS

As a condition precedent to the approval of claims hereunder, each Member authorizes and directs any Provider who furnished benefits hereunder to make available to CHL information relating to all treatment, copies thereof and other records as needed by CHL. CHL and any of its Designees shall have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of this Rider or for appropriate medical review or quality assessment.

ARTICLE 5. GENERAL PROVISIONS

(a) A Member's Coverage under this Rider will end when such person's Coverage under the entire Benefit Agreement to which this Rider is attached ends.

(b) Nothing herein contained shall be held to vary, alter, waive, or extend any of the definitions, terms, conditions, provisions, agreements or limitations of the entire Benefit Agreement to which this Rider is attached, other than as stated above.

(c) All definitions, terms, conditions, provisions, agreements or limitations of the entire Benefit Agreement to which this Rider is attached shall apply except to the extent such terms are explicitly superceded or modified by this Rider.

COVENTRY HEALTH AND LIFE INSURANCE COMPANY

PRESCRIPTION DRUG RIDER ("Rider)

This Rider is underwritten and administered by Coventry Health and Life Insurance Company ("CHL") and made a part of the Individual Certificate of Coverage ("COC") to which it is attached. Accordingly, all definitions, provisions, terms, limitations, exclusions, and conditions of the COC apply to this Rider except to the extent such terms and conditions are explicitly superceded or modified by this Rider.

The additional benefits provided by this Rider become effective on the date that You purchased ("Effective Date") this supplemental Rider and expires when Your Coverage under this Rider terminates.

1. DEFINITIONS

The following definitions apply to this Rider.

a. Covered Drugs - Prescription Drugs [and Self Administered Injectables] [and Specialty Drugs], which are prescribed by a Participating Physician, included on the then-current Drug Formulary, approved by CHL and not otherwise excluded from Coverage based upon the exclusions listed in the COC and in section 5 of this Rider. Covered Drugs, under this Rider, are those dispensed in generic form, unless a generic equivalent does not exist, or unless the Tier 2 or the Tier 3 benefit is available and is being accessed. Some Covered Drugs may not be authorized as treatment for Your diagnosis. A list of these Covered Drugs can be found on the website along with the criteria for their approval.

b. Drug Formulary - a listing of specific generic and brand name Prescription Drugs which are approved for use by CHL and which will be dispensed to You through a Participating Pharmacy. This list shall be subject to periodic review and modification by CHL at its discretion.

c. Experimental Drug(s) - means pharmacological regimes that are:

(i) Any drug not approved for use by the United States Food and Drug Administration ("FDA"); any FDA approved drug prescribed for an off-label use whose effectiveness is unproven based on clinical evidence reported in Peer-Reviewed medical literature or any drug that is classified as IND (investigational new drug) by the FDA; or

(iii) Any health product or service that is subject to Institutional Review Board (IRB) review or approval; or

(iv) Any health product or service that is the subject of a clinical trial that meets criteria for Phase I, II or III as set forth by FDA regulations; or

(v) Any health product or service that is unproven based on clinical evidence reported by Peer-Reviewed medical literature.

d. Mail Order" means a 90 day supply through a participating mail order pharmacy.

e. Monthly Supply - the lesser of:

(i) The quantity prescribed in the Prescription Order or Prescription Refill; or

(ii) A thirty-one (31) day supply as defined by the Plan; or

(iii) The amount necessary to provide a 31 day supply according to the maximum dosage approved by the FDA for the indication for which the drug is prescribed.

(iv) Depending on the form and packaging of the product, the following:

(a) Tablets/capsules/suppositories - 100

(b) Oral liquids - 480 cc;

(c) Prepackaged items (i.e., topicals, inhalers, etc.) - 1 unit (i.e., 1 box, 1 tube, 1 inhaler, etc.);

(d) [One bottle of insulin;]

(e) Any items that are dispensed in the original manufacturer's packaging.

(v) An amount as defined by the Plan

f. Non-Formulary Drugs - Prescription Drugs that are not subject to an exclusion under the COC or this Rider, and that are not included on the Drug Formulary at the time the Prescription Drug is dispensed by a Participating Pharmacy. Non-Formulary Drugs may include either generic or brand name Prescription Drugs.

g. Participating Pharmacy - any registered, licensed pharmacy with whom CHL has contracted to dispense Prescription Drugs to Members.

h. Prescription Drug - a drug that is provided for outpatient administration, which has been approved by the Food and Drug Administration for a specific use and which can, under Federal or State law, be dispensed only pursuant to a Prescription Order. A compound substance is considered a Prescription Drug if one or more of the items compounded is a Prescription Drug. This definition includes insulin.

i. Prescription Order or Refill - the authorization for a Prescription Drug issued by a Participating Physician who is duly licensed to make such an authorization in the ordinary course of his or her professional practice.

j. Retail - a 31 day supply or less. A Member will be assessed a retail copay for each 31 day or less supply dispensed to a Member.

k. [Self Administered Injectable – Drugs that as defined by CHL are commonly and customarily administered by the Member and are Covered only when dispensed by the Specialty Pharmacy or other Pharmacy designated by CHL. Examples of Self-Administered Injectable Drugs include, but are not limited to, the following:

multiple sclerosis agents, growth hormones, colony stimulating factors, chronic medications for hepatitis C, certain rheumatoid arthritis medications, certain injectable HIV drugs, certain osteoporosis agents and heparin products. Note: For definition purposes, other injectable drugs that are acquired through the retail pharmacy, injectable diabetes agents (such as insulin and glucagons), bee sting kits, Imitrex and injectable contraceptive are not considered to be Self Administered Injectables.]

l. [Specialty Drugs – Plan defined, typically high-cost drugs, including the oral, topical, inhaled, and injected routes of administration. Included characteristics of Specialty Medications are:

- Drugs that are used to treat rare or complex diseases;
- Require close clinical monitoring and management;
- Frequently require special handling; and
- May have limited access or distribution.]

m. Specialty Pharmacy – a pharmacy designated by the Plan to provide certain medications Covered under the pharmacy benefit, including, but not limited to, Self Administered Injectable medication.

n. [Transition Rx-Designated pharmacy riders with the Transition Rx program allows new members within the first 90 days of their effective date a one time fill up to a 30 day supply of certain covered prescription drugs without being subject to the prior authorization, step therapy, and/or once daily quantity limits. Self-administered injectables/Specialty drugs are not included in this program. Members are notified via letter that a transition fill has been obtained, indicating for which drug, and the necessary actions to obtain a refill.]

o. Value Formulary or Tier 0 Drugs – The group of medications on the formulary addendum, Value Formulary Tier 0 Drugs, that are available for a limited period of time at no Copayment to Members who meet the plan criteria specified in the formulary addendum.

Note: This Rider applies to outpatient Prescription Drugs only.

2. ELIGIBLE CHARGES/DRUG BENEFIT COVERAGE

2.1 Tier 1

You are entitled to obtain Coverage for Covered Drugs as listed in the Drug Formulary in the quantities specified below from a Participating Pharmacy upon payment of the applicable Copayment [and Deductible].

[Copayment:
[0-50%] or [$0 - $50] Per generic Covered Drug]

[**Tier 2**

You are entitled to obtain Coverage for formulary drugs in the quantities specified below from a Participating Pharmacy upon payment of the applicable Copayment [and Deductible].

Copayment:

[0-50%] or [$0-$100]] Per brand name Covered Drug]

[**Tier 3**

You are entitled to obtain Coverage for non-formulary drugs in the quantities specified below from a Participating Pharmacy upon payment of the applicable Copayment [and Deductible].

Copayment:

[0-50%] or [$0-$100] Per Non-Formulary Drug]

[**Tier 4**

You are entitled to obtain Coverage for [preferred] Specialty Drugs in the quantities specified below from a pharmacy upon payment of the applicable Copayment [and Deductible].

Copayment:

[0-50%] or [$0-$500] Per Specialty Drug

[Benefit limited to [$2,000-unlimited.]]

[**Tier 5**

You are entitled to obtain Coverage for non-preferred Specialty Drugs in the quantities specified below from a pharmacy upon payment of the applicable Copayment [and Deductible].

Copayment:

[0-50%] or [$0-$500] Per Specialty Drug

[Benefit limited to [$2,000-unlimited.]]

[**Tier 0**

Value Formulary or Tier 0 Drugs are offered at no Copayment on a **temporary** basis to members that are on or have recently received **certain drugs(s) and/or receive a new prescription for certain drug(s), as designated by the Plan ("Plan Criteria")** to promote effective and efficient use of the Plan drug benefits. These drugs are listed in an addendum to the formulary, found on the Plan's website. The formulary addendum shall also identify the Plan Criteria applicable to the Value Formulary Drugs. **The formulary addendum may change from time to time without prior notice.** Members that appear to meet the Plan Criteria for Value Formulary Drugs (as such information is available in

Plan's claims records) will be notified if they qualify for a Value Formulary Drug, when such drugs are temporarily added. Please note, just because a Member fills a prescription for a Value Formulary Drug does not qualify him/her for the Value Formulary Drug copayment. Rather, only Members that meet Plan Criteria will receive the selected drug at Value Formulary Drug copayment. Therefore, there may be instances where a drug is a Value Formulary Drug and on Tier 1 or Tier 2. If a Member does not satisfy the Value Formulary Drug Plan Criteria, the drug shall be subject to a Tier 1 or Tier 2 copayment, as applicable.

[Deductible

An annual Deductible, which applies to Tiers [1, 2, 3, 4, 5] must be satisfied each Contract Year before a Member may receive coverage for Prescription Drugs under this Rider.

The annual Deductible for an individual plan is $[50-3000].

The annual Deductible for a family plan is [two times (2x); three times (3x)] the individual Deductible. The Deductible for a two (2) person family will always be two (2) times the individual Deductible.]

[**Deductible for QHDHP –** The medical Deductible must be satisfied before Pharmacy benefits apply. See Your Schedule of Benefits for Individual and/or Family Deductible amounts.]

2.2 Quantity

A. The quantity of a Covered Drug dispensed upon payment of a single Copayment shall be limited to a Monthly Supply as defined in Section 1(d).

B. The Coverage for a Covered Drug or Prescription Drug dispensed pursuant to a Prescription Order on a monthly basis cannot exceed an amount sufficient to provide for a thirty-one (31) day supply.

2.3 Generic Substitution

[When a generic is available and substitution is required, but the pharmacy dispenses the brand name drug for any reason, the Member is to pay the cost difference between the CHL contracted price for the brand name drug and the CHL maximum allowed cost for the generic drug in addition to the Tier 2 copayment]; [or]

[When a generic is available and substitution is required, but the pharmacy dispenses the brand name drug for any reason, the Member is to pay the cost difference between the CHL contracted price for the brand name drug and the CHL maximum allowed cost for the generic drug in addition to the Tier 1 copayment]; [or]

[When a generic is available, but the pharmacy dispenses the brand name drug for any reason, the Member is not required to pay any additional amount beyond the Tier 3 copayment]; [or]

[When a generic is available, but the pharmacy dispenses the brand name drug for any reason, the Member is not required to pay any additional amount beyond the Tier 2 copayment]; [or]

[When a generic is available, but the pharmacy dispenses the brand name drug for any reason other than the doctor specifies substitution with the generic is not allowed, the Member is to pay the difference between the CHL contract price for the brand name drug and the CHL maximum allowed cost for the generic drug in addition to the Tier 2 copayment]

2.4 Limitations

1) [Written proof of loss (i.e. cancelled check, credit card statement, receipt) and a completed claim form must be submitted to the Plan within ninety (90) days of the date of the loss. Failure to furnish such proof within the ninety (90) days shall not invalidate nor reduce any claim if it was not reasonably possible to furnish such proof within the ninety (90) days, provided such proof is furnished as soon as is reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one (1) year from the time proof is otherwise required.]

2) [The Plan reserves the right to include only one manufacturer's product on our Drug Formulary when the same drug (i.e., a drug with the same active ingredient) is made by two or more different manufacturers. The product that is listed on the Drug Formulary will be Covered at the applicable Copayment. The product or products of the same drug not listed on the Drug Formulary will be excluded from Coverage.]

3) [The Plan reserves the right to include only one dosage or form of a drug on our Drug Formulary when the same drug (i.e., a drug with the same active ingredient) is available in different dosages or forms (i.e., dissolvable tablets, capsules, etc) from the same or different manufacturers. The product, in the dosage or form, that is listed on the Drug Formulary will be Covered at the applicable Copayment. The product or products, in different forms or dosages, not listed on the Drug Formulary will be excluded from coverage.]

4) [In order to receive this benefit, You must present Your CHL ID card at the time the prescription is filled. Prescriptions filled at Participating Pharmacies must be submitted through the online claims adjudication process. The pharmacy will then charge You the applicable Copayment or Deductible amount up to the cost of the drug. CHL will not reimburse Members who fail to follow this procedure.]

5) [CHL does not coordinate benefits with other carriers for services and supplies offered under the Prescription Drug Rider.]

6) [If You have pharmacy coverage under more than one insurance plan and CHL is secondary to the other plan (see your COC to determine who is primary), CHL will

coordinate benefits and pay Your Copayment or Deductible from the primary plan up to the amount CHL would have paid if it were the primary insurance company. You must use your primary insurance when you have the prescription filled. For CHL to pay secondary, You must use a CHL Participating Pharmacy and the items must be Covered by CHL based on the benefits purchased by Your employer. (Your primary insurance plan's mail order provider is usually not a CHL Participating Provider and therefore Your Member responsibility would not be Covered by CHL.) The pharmacy will not submit Your Member responsibility for You, so after You have received Your prescription and paid You primary coverage Copayment or Deductible, submit the pharmacy bill to CHL for reimbursement.]

3 [Specialty Drugs] [and] [Self-Administered Injectables]

Self-Administered Injectable Drugs are Covered under this Rider in the amounts described below when they are:

1) Ordered by a prescriber for use by a Member; and
2) Not limited or excluded elsewhere in this Rider or Your COC; and
3) Obtained from a Specialty Pharmacy; and
4) Prior Authorized [;and]
5) [Listed on Our Formulary]

[Generic drugs will always be substituted when a generic Prescription Drug is available. If you choose to receive a brand name Prescription Drug when a generic Prescription Drug is available, You will be responsible for the difference in cost between the brand and generic plus the Tier [2, 3, 4, or 5] Copayment.]

Filling Your Prescription Order or Refill. Self-Administered Injectable Drugs are NOT available through the Mail Order Pharmacy program or at Participating Retail Pharmacies. You must fill Your Prescription Order or Refill for Self-Administered Injectable Drugs through the Specialty Pharmacy.

Depending on the Rider purchased, You may pay the following to a Specialty Pharmacy, as applicable:

1) Prescription Drug Deductibles;
2) The difference in cost between the brand and generic plus the Tier 2 or Tier 3 Copayment;
3) Amounts above the annual maximum; and
4) One (1) Self-Administered Injectable Drug Copayment per Prescription Order or Refill.

General Quantity Limits. In general, the quantity of a Self-Administered Injectable Drug dispensed by a Specialty Pharmacy for each Prescription Order or Refill is limited to the lesser of:

1) The amount prescribed in the Prescription Order or Refill; or
2) The amount determined by the Plan to be Medically Necessary; or

3) The amount determined by the Plan to be a thirty-one (31) day supply.

4. MAINTENANCE DRUG PROGRAM

A. Preferred Copayment Method. The Coverage for a Covered Drug or Prescription Drug dispensed for the purpose of maintenance from either CHL's designated mail order provider or through a maintenance pharmacy contracted to provide a ninety (90) day supply subject to the quantity limits in Section 1(d), Monthly Supply, at the preferred rate upon payment of [1-3] Copayments shall be an amount sufficient to provide for no more than a three (3) month supply. Notwithstanding the foregoing, Prescription Drugs that require close monitoring, Prescription Drugs that are considered controlled substances by federal or state law, or as otherwise determined by CHL may not be ordered through CHL's mail order provider.

B. [Standard Copayment Method. If you wish to obtain a ninety (90) day supply of maintenance drugs from any other CHL Participating Pharmacy, other than CHL's designated mail order or maintenance provider, you must pay a Copayment of [0-50%].]

C. Notwithstanding the foregoing, CHL may provide Coverage for any drug dispensed in the original manufacturer packaging which contains a 90 day or 12 week supply or that has a duration of action of 12 weeks or longer upon payment of three (3) Copayments including but not limited to Depo-provera and Seasonale.

5. DISCOUNTS AND REBATES

Member understands and agrees that Health Plan may receive a retrospective discount or rebate from a Network Provider or vendor related to the aggregate volume of services, supplies, equipment or pharmaceuticals purchased by persons enrolled in health care plans offered or administered by Health Plan and its affiliates. Member shall not share in such retrospective volume-based discounts or rebates. However, such rebates will be considered, in the aggregate, in Health Plan's prospective premium calculations.

6. EXCLUSIONS

The cost of the following drugs is specifically excluded from this benefit provided by this Rider and is not Covered, *even* if prescribed by a Participating Physician and dispensed at a Participating Pharmacy:

a) Devices or supplies of any type, even though such devices may require a Prescription Order, including, but not limited to, therapeutic devices, artificial appliances, non-disposable hypodermic needles, syringes including pre-filled insulin syringes or devices used to assist in insulin injection (except disposable syringes [, glucose strips, lancets, glucose monitor,] or any other medically necessary, FDA approved medication [which is listed on the Drug Formulary] for use in the treatment of diabetes), support garments, or other devices, regardless of their intended use, except as specifically listed as a Covered Service in the COC or any applicable rider.

b) Drugs prescribed and administered in the Physician's office or any other drug Covered under Your COC.

c) Drugs that do not, by Federal or State law, require a prescription, including over-the-counter (OTC) drugs, or Prescription Drugs with OTC equivalents (e.g., Benadryl 25 mg., etc.), even if prescribed in generic form, unless specifically noted in the Drug Formulary.

d) Experimental or investigational drugs or drugs prescribed for experimental (non-FDA approved/unlabeled) indications.

e) Drugs used for athletic performance enhancement (such as anabolic steroids) [, sexual dysfunction,] or primarily for cosmetic purposes, including, but not limited to, drugs prescribed for prevention of wrinkles, onychomycosis or hair loss.

f) The cost of special packaging required for drugs dispensed in nursing homes.

g) Injectables other than Self Administered Injectables [and Specialty Drugs] (as defined in this rider and designated by the Plan), Glucagon, insulin, Imitrex and bee sting kits. Refer to your COC for information regarding Coverage of injectables as a medical benefit.

h) Nicorette (nicotine gum), nicotine patches, Zyban, or other drugs primarily used as part of a smoking cessation program.

i) Vitamins and minerals (both OTC and prescription), except prescription prenatal vitamins for pregnant/nursing females, and liquid or chewable prescription pediatric vitamins for children.

j) Refill prescription resulting from loss or theft or resulting damage by the Member.

k) Dietary supplements, appetite suppressants, and other drugs used to treat obesity or assist in weight reduction and malabsorption agents.

l) Growth hormones with the exception of those prescribed for a congenital anomaly such as Turner's Syndrome.

m) Prescription drugs not considered as Covered Drugs or related to a Non-Covered Service.

n) Prescription Drugs taken for travel including but not limited to, medications devices and supplies for motion sickness or travel-related disease (e.g. Relief bands).

o) Progesterone for the treatment of premenstrual syndrome (PMS) and compounded natural hormone therapy replacement.

p) Oral dental preparations and fluoride rinses except fluoride tablets or drops.

q) Compounded prescriptions are excluded unless all of the following apply:
   (i) there is no suitable commercially-available alternative available; and
   (ii) the main active ingredient is a Covered Prescription Drug; and
   (iii) the purpose is solely to prepare a dose form that is Medically Necessary and is documented by the prescriber; and

(iv) the claim is submitted electronically by a Participating Pharmacy.

r) Prescription Drugs ordered by a dentist or medications prescribed by an oral surgeon in relation to removal of teeth; or Prescription Drugs for the treatment of a dental condition.

s) Any Prescription Drug that is being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, the use of or intended use of which would be illegal, unethical, imprudent, abusive, not Medically Necessary, or otherwise improper; and drugs obtained by unauthorized, fraudulent, abusive, or improper use of the Member identification card, including drugs obtained for use by anyone other than the Member identified on the identification card;

t) Contraceptive implant systems and intrauterine devices (IUDs);

u) Drugs obtained from non-participating pharmacies in a non-emergency situation.

v) [Prescription Drugs for the treatment of infertility.]

Schedule of Benefits

This Schedule is part of Your COC but does not replace it. Many words are defined elsewhere in the COC, and other limitations or exclusions may be listed in other sections of Your COC. Reading this Schedule by itself could give You an inaccurate impression of the terms of Your Coverage. This Schedule must be read with the rest of Your COC. [This is a QHDHP. Please see Section 2.10 For additional information regarding Your benefits.] Coinsurance amounts are a percentage of the Plan's Out of Network Rate (ONR). See the last page of this Schedule of Benefits for further explanation.

Member Responsibility	**In-Network**	**Out-of Network**
Annual Deductible Total amount a Member is required to pay each calendar year or Contract Year before he or she is eligible for certain Health Services. The Annual Deductible need only be met once per Member per calendar or Contract Year. **In some cases, In-network Deductible will not apply.**	Individual [$0-$15,000] [Family [$0-$30,000]]	Individual [$0-$30,000] [Family [$0-$ 45,000]]
Annual Out-of-Pocket Maximum [Copayments,] [Annual Deductible,] [and] [Coinsurance] apply to the Out-of-Pocket Maximum	Individual [$0-$25,000] [Family [$0-$75,000]]	Individual [$0-$50,000] [Family [$0-$150,000]]
[Maximum Annual Benefit Combined total of all benefits each calendar year.	Individual [$10,000-unlimited] [Family [$10,000-unlimited]]	Individual [$10,000-unlimited] [Family [$10,000-unlimited]]]
Maximum Lifetime Benefit Combined total of all benefits.	[$1,000,000-Unlimited]	[$1,000,000-Unlimited]
Physician Office - Preventive Care Services include routine health assessment, well-child care, child health supervision services, childhood immunizations and injections, hearing test, annual self-referred gynecological examination and pap smear, and mammogram screening.	For Primary Care Services [$0-$250 Copay per visit] [or] [then] [0-50% Coinsurance per visit] [after Deductible] [4-unlimited visits] [Deductible does not apply to the initial $200-$500] of Preventive Care Services per	For Primary Care Services [$0-$250 Copay per visit] [or] [then] [0-50% of ONR Coinsurance per visit] [after Deductible] [4-unlimited visits] [Deductible does not apply to the initial $200-$500] of Preventive Care

YOU ARE RESPONSIBLE FOR AMOUNTS IN EXCESS OF OUT-OF-NETWORK RATES (ONR) IN ADDITION TO APPLICABLE COMPAYMENT, COINSURANCE AND DEDUCTIBLES.

[Visit limitation is an In-Network and Out of Network combined limit.]	calendar/Contract Year] For Specialty Care Services [$0-$250 Copay per visit] [or][then[[0-50% Coinsurance per visit] [after Deductible]	Services per calendar/Contract Year] For Specialty Care Services [$0-$250 Copay per visit] [or][then[[0-50% of ONR Coinsurance per visit] [after Deductible]
Physician Office – Medical Services Services include diagnosis, consultation and treatment, diagnostic tests and radiology services, immunizations and injections, surgery, allergy tests and treatment. [Visit limitation is an In-Network and Out of Network combined limit.]	For Primary Care Services [$0-$250 Copay per visit] [or][then[[0-50% Coinsurance per visit] [after Deductible] For Specialty Care Services [$0-$250 Copay per visit] [or][then[[0-50% Coinsurance per visit] [after Deductible]	For Primary Care Services [$0-$250 Copay per visit] [or] [then] [0-50% of ONR Coinsurance per visit] [after Deductible] For Specialty Care Services [$0-$250 Copay per visit] [or][then[[0-50% of ONR Coinsurance per visit] [after Deductible]
Chiropractic Office Visits Services include treatment that is Medically Necessary, clinically appropriate, and within the chiropractor's scope of practice. [Visit limitation is an In-Network and Out of Network combined limit.]	[$0-$250 Copay per visit] [or] [then] [0-50% Coinsurance per visit] [after Deductible] [10-unlimited visits]	[$0-$250 Copay per visit] [or] [then] [0-50% of ONR Coinsurance per visit] [after Deductible] [10-unlimited visits]
Emergency Room Services Coverage is provided for worldwide Emergency Health Services as defined in Section 1"Definitions" of the COC.	[$0-$500 Copay per visit] [or] [then] [0-50% Coinsurance per visit] ([Copay; Coinsurance] waived if the patient is admitted) [after Deductible]	[$0-$500 Copay per visit] [or] [then] [0-50% of ONR Coinsurance per visit] ([Copay; Coinsurance] waived if the patient is admitted) [after Deductible]
Emergency Ambulance Services Coverage is provided for Emergencies as defined in Sections [1.41] and 6 of the COC.	[$0-$500 Copay per occurrence] [or] [then] [0-50% Coinsurance per occurrence] [after Deductible]	[$0-$500 Copay per occurrence] [or] [then] [0-50% of ONR Coinsurance per occurrence] [after Deductible]
Urgent Care Services Urgent Care Services at Alternate Facilities both in and out of the Service	[$0-$500 Copay per visit] [or] [then] [0-50% Coinsurance per visit]	[$0-$500 Copay per visit] [or] [then] [0-50% of ONR Coinsurance per

Area are Covered.	[after Deductible]	visit] [after Deductible]
Outpatient Services and Diagnostic Procedures and Tests Coverage includes diagnostic procedures and tests, including but not limited to lab and radiology, not performed in the Physician's office. Certain procedures and tests are considered surgery, including but not limited to colonoscopy and endoscopy. Refer to the Outpatient Surgery section.	[$0-$500 Copay per visit] [or] [then] [0-50% Coinsurance per visit] [after Deductible] [0-20% penalty for failure to precertify]	[$0-$500 Copay per visit] [or] [then] [0-50% of ONR Coinsurance per visit] [after Deductible] [0-20% penalty for failure to precertify]
Outpatient Surgery Benefits are provided for Covered Services rendered at an outpatient Hospital and may include an overnight observation stay.	[$0-$500 Copay per visit] [or] [then] [0-50% Coinsurance per visit] [up to a maximum of $0-$2000] [per calendar year; Contract Year] [after Deductible] [0-20% penalty for failure to precertify]	[$0-$500 Copay per visit] [or] [then] [0-50% of ONR Coinsurance per visit] [up to a maximum of $0-$2000] [per calendar year; Contract Year] [after Deductible] [0-20% penalty for failure to precertify]
[High Technology Diagnostic Services, Tests, and Procedures Including, but not limited to: MRI, MRA, CT Scans, Thallium Scans, Nuclear Stress Tests, PET Scans, Echocardiograms, Ultrasounds	[$0-$500 Copay per visit] [or] [then] [0-50% Coinsurance per visit] [up to a maximum of $0-$2000] [per calendar year; Contract Year] [after Deductible] [0-20% penalty for failure to precertify]	[$0-$500 Copay per visit] [or] [then] [0-50% of ONR Coinsurance per visit] [up to a maximum of $0-$2000] [per calendar year; Contract Year] [after Deductible] [0-20% penalty for failure to precertify]]
[Outpatient Surgery Freestanding Facility Benefits are provided for Covered Services rendered at a Freestanding surgery center.	[$0-$500 Copay per visit] [or] [then] [0-50% Coinsurance per visit] [up to a maximum of $0-$2000] [per calendar year; Contract Year] [after Deductible] [0-20% penalty for failure to precertify]	[$0-$500 Copay per visit] [or] [then] [0-50% of ONR Coinsurance per visit] [up to a maximum of $0-$2000] [per calendar year; Contract Year] [after Deductible] [0-20% penalty for failure to precertify]]

[Allergy Injections Covered Service for allergy serum, and the administration of injections. There may be more than one Copayment charged by the same provider on the same day.	[$0-$500 Copay] [or] [then] [0-50% Coinsurance] [up to a maximum of $0-$500] per injection [after Deductible]	[$0-$500 Copay] [or] [then] [0-50% of ONR Coinsurance] [up to a maximum of $0-$500] per injection [after Deductible]]
[Chemotherapy Covered Service for standard chemotherapy for the treatment of cancer. There may be more than one Copayment charged by the same provider on the same day.	[$0-$500 Copay] [or] [then] [0-50% Coinsurance] [up to a maximum of $0-$500] per injection [after Deductible]	[$0-$500 Copay] [or] [then] [0-50% of ONR Coinsurance] [up to a maximum of $0-$500] per injection [after Deductible]]
[Therapeutic Injectables Covered Service for Injectable medications. There may be more than one Copayment charged by the same provider on the same day.	[$0-$500 Copay] [or] [then] [0-50% Coinsurance] [up to a maximum of $0-$500] per injection [after Deductible]	[$0-$500 Copay] [or][then] [0-50% of ONR Coinsurance] [up to a maximum of $0-$500] per injection [after Deductible]]
[Injectables Includes Injectable medications, and chemotherapy. There may be more than one Copayment charged by the same Provider on the same day.	[$0-$500 Copay] [or] [then] [0-50% Coinsurance] [up to a maximum of $0-$500] per injection with the exception of immunizations [after Deductible]	[$0-$500 Copay] [or] [then] [0-50% of ONR Coinsurance] [up to a maximum of $0-$500] per injection with the exception of immunizations [after Deductible]]
Inpatient Hospital Services Coverage is provided for Medically Necessary Physician and surgeon services, Semi-private room, operating rooms and related facilities, intensive and coronary care units, laboratory, x-rays, radiology services and procedures, medications and biologicals, anesthesia, special duty nursing as prescribed, short-term rehabilitation services, nursing care, meals and special diets.	[$0-$1000 Copay] [or][then] [0-50% Coinsurance] [per admission; per day] [up to a maximum of $0-$2000] [per calendar year; Contract Year] [after Deductible] [$0-$1000 penalty for failure to precertify]	[$0-$1000 Copay] [or][then] [0-50% of ONR Coinsurance] [per admission; per day] [up to a maximum of $0-$2000] [per calendar year; Contract Year] [after Deductible] [$0-$1000 penalty for failure to precertify]
Transplant Services Services and supplies for certain transplants are Covered.	[$0-$1000 Copay] [or][then] [0-50% Coinsurance] [per	[[$0-$1000 Copay] [or][then] [0-50% of ONR Coinsurance] [per

Donor screening testing is limited to a [$10,000-$20,000] benefit maximum per Member per Lifetime. This is a combined in-network and out-of-network limit.	admission; per day] [up to a maximum of $0-$2000] [per calendar year; Contract Year] [after Deductible] [$0-$1000 penalty for failure to precertify]	admission; per day] [up to a maximum of $0-$2000] [per calendar year; Contract Year] [after Deductible] [$0-$1000 penalty for failure to precertify]]
Skilled Nursing Facility Coverage is provided in lieu of an inpatient Hospital admission when approved by the Plan. Coverage is provided on a Semi-private basis. [Maximum benefit is an In-Network and Out of Network combined limit.]	[$0-$1000 Copay] [or][then] [0-50% Coinsurance] [per admission; per day] [up to a maximum of $0-$2000] [per calendar year; Contract Year] Limited to [0-150] days per [calendar year; Contract Year] [after Deductible] [$0-$1000 penalty for failure to precertify]	[$0-$1000 Copay] [or][then] [0-50% of ONR Coinsurance] [per admission; per day] [up to a maximum of $0-$2000] [per calendar year; Contract Year] Limited to [0-150] days per [calendar year; Contract Year] [after Deductible] [$0-$1000 penalty for failure to precertify]
Home Health Care Coverage is provided when services are rendered by licensed Providers and Authorized in advance by the Plan. [Maximum benefit is an In-Network and Out of Network combined limit.]	[$0-$500 Copay per visit] [or] [then] [0-50% Coinsurance per visit] [Limited to 20-50 visits per calendar year; Contract Year][after Deductible] [0-20% penalty for failure to precertify]	[$0-$500 Copay per visit] [or] [then] [0-50% of ONR Coinsurance per visit] [Limited to 20-50 visits per calendar year; Contract Year] [after Deductible] [0-20% penalty for failure to precertify]
Hospice Coverage is provided when services are rendered by licensed Providers and Authorized in advance by the Plan. [Maximum benefit is an In-Network and Out of Network combined limit.]	[$0-$500 Copay per visit] [or] [then] [0-50% Coinsurance per visit] [Limited to 20-50 visits per calendar year; Contract Year][[after Deductible] [0-20% penalty for failure to precertify]	[$0-$500 Copay per visit] [or] [then] [0-50% of ONR Coinsurance per visit] [Limited to 20-50 visits per calendar year; Contract Year] [after Deductible] [0-20% penalty for failure to precertify]
Durable Medical Equipment (DME), Orthotics and Prosthetics Coverage is provided when services are rendered by Providers and Authorized in advance by the Plan. [Maximum benefit is an In-Network and Out of Network combined limit.]	[0-50% Coinsurance of Covered expenses] [after Deductible] [limited to a benefit maximum of $1000-$20,000] [0-20% penalty for failure to precertify]	[0-50% of ONR Coinsurance of Covered expenses] [after Deductible] [limited to a benefit maximum of $1000-$20,000] [0-20% penalty for failure to

		precertify]
[Eyeglasses and Contacts Coverage is provided for the first pair of eyeglasses or corrective lenses following cataract surgery [Maximum benefit is an In-Network and Out of Network combined limit.]	100% of Covered eyewear up to [$50-$500]	[0-50% Coinsurance of Covered expenses] [after Deductible]]
[Hearing Aids Coverage is provided for hearing aids. [Maximum benefit is an In-Network and Out of Network combined limit.]	[$0-$500 Copay per hearing aid] [or] [then] [0-50% Coinsurance per hearing aid] [limited to a benefit maximum of $250-$5000] [after Deductible]	[$0-$500 Copay per hearing aid] [or] [then] [0-50% of ONR Coinsurance per hearing aid] [limited to a benefit maximum of $250-$5000] [after Deductible]]
Physical, Occupational, and Speech Therapy Coverage is provided for Medically Necessary inpatient or outpatient physical, occupational, and speech therapy when Authorized in advance by the Plan. [Maximum benefit is an In-Network and Out of Network combined limit.]	[$0-$500 Copay per visit] [or] [then] [0-50% Coinsurance per visit] [after Deductible] [0-20% penalty for failure to precertify] [Physical therapy: 20-unlimited visits] [Occupational therapy: 20-unlimited visits] [Speech therapy: 20-unlimited visits] [10-60 combined visits]	[$0-$500 Copay per visit] [or] [then] [0-50% of ONR Coinsurance per visit] [after Deductible] [0-20% penalty for failure to precertify] [Physical therapy: 20-unlimited visits] [Occupational therapy: 20-unlimited visits] [Speech therapy: 20-unlimited visits] [10-60 combined visits

OUT OF NETWORK RATE (ONR)

The "Out-of-Network Rate" or "ONR" is the amount the Plan pays for Covered Services rendered by a Non-Participating Provider for Out-of-Network Benefits. When services are rendered by a Non-Participating Provider, benefits may be paid directly to You upon receipt of Your claim submission.

The ONR is the lesser of the Provider's billed charges or 100% of the current Medicare fee schedule. (Please note that the Medicare fee schedule is updated April 1 of each year.) If there is no corresponding Medicare rate noted for a particular service, the Plan will determine the payment to the Provider. .

Please Note: You are responsible for paying any expenses or charges in excess of the ONR.

The examples below illustrate how ONR works:

Assume Your Hospital Coinsurance is 20%, the Hospital bill is $5,000 (actual charges), and the ONR for the Hospital is $3,000. In this example, the Plan would not take into account $2,000 of the $5,000 Hospital bill, because it exceeds the $3,000 ONR. The Plan would pay 80% of the $3,000 ONR, which is $2,400. You would pay 20% of the $3,000 ONR, which is $600, ***PLUS*** the $2,000 of actual charges that exceed the $3,000 ONR, for a total cost to You of $2,600. Please note that any payments You make in excess of the ONR do not count towards Your Deductible or Out of Pocket Maximum.

Assume Your Specialist visit Copayment is $50. The Specialist's bill is $140 (actual charges) and the ONR for the Specialist is $80. In this example, The Plan would not take into account $60 of the Specialist's bill because it exceeds the $80 ONR. The Plan would pay $30 (the ONR minus Your Copayment amount). You would pay the $50 Copayment ***PLUS*** the $60 of actual charges that exceed the $80 ONR, for a total cost to You of $110. Please note that any payments You make in excess of the ONR do not count towards Your Deductible or Out of Pocket Maximum.

By way of contrast, the examples below illustrate how In-Network Covered Services would be paid:

Assume Your In-Network Hospital Coinsurance is 20%, the Hospital bill is $5,000 (actual charges), and the contracted rate for the Hospital is $3,000. In this example, the Plan would not take into account $2,000 of the $5,000 Hospital bill, because it exceeds the $3,000 contracted rate. The Plan would pay 80% of the $3,000 contracted rate, which is $2,400. You would pay 20% of the $3,000 contracted rate, which is $600. The amount in excess of the contracted rate would not be Your responsibility.

Assume Your Specialist visit Copayment is $50. The Specialist's bill is $140 (actual charges) and the contracted rate for the Specialist is $80. In this example, the Plan

would not take into account $60 of the Specialist's bill because it exceeds the $80 contracted amount. The Plan would pay $30 (the contracted rate minus Your Copayment amount). You would pay the $50 Copayment. The amount in excess of the contracted rate would not be Your responsibility.

SUPPLEMENTAL RIDER FOR TEMPOROMANDIBULAR JOINT DISORDER TREATMENT

This Rider is underwritten by Coventry Health and Life Insurance Company ("CHL"), issued to [the Group] [You] on the Effective Date and is made a part of the entire Benefit Agreement to which it is attached. Accordingly, all definitions, provisions, terms, limitations, exclusions and conditions of the Certificate of Coverage ("COC") apply to this Rider except to the extent such terms and conditions are explicitly superceded or modified by this Rider.

The benefits provided by this Rider become effective on the date that [the Group] [You] purchased ("Effective Date") this supplemental Rider and expires when [the Group's] [Your]Coverage under this Rider terminates.

Article 1. Covered Services

1. Coverage is provided for Medically Necessary treatment related to musculoskeletal disorders affecting any bone or joint in the face, neck, or head, including temporomandibular joint disorder (TMJ) and craniomandibular disorder (CMD).
2. [Benefit is limited to a maximum of $[2500-10,000] per Lifetime.]
3. Treatment must be Authorized by the Plan.

Article 2. Benefits

In-Network: All services are subject to a [$[0-100] Copayment] [and] [or] [[0-50%] of ONR Coinsurance] [and] [or] [$[0-5,000] individual Deductible]. The family Deductible will be [two; three] [(2); (3)] times the individual Deductible. For a two-person family, the family Deductible will always be two (2) times the individual Deductible.

Out-of-Network: All services are subject to a [$[0-100] Copayment] [and] [or] [[0-50%] of ONR Coinsurance] [and] [or] [$[0-5,000] individual Deductible]. The family Deductible will be [two; three] [(2); (3)] times the individual Deductible. For a two-person family, the family Deductible will always be two (2) times the individual Deductible.

[This Copayment does not apply to the Annual Out-of-Pocket Maximum listed on the Schedule of Benefits.]

Article 3. Exclusions

1. Services not Authorized by the Plan.
2. Cosmetic procedures.

Article 4. General Provisions

1. The Rider, or Coverage under this Rider, shall terminate for the reasons set forth in the COC.

2. Nothing in this Rider shall otherwise extend, vary, alter or waive any of the benefits, exclusions, limitations or conditions contained in the COC, other than as stated in this Rider.

3. As a condition precedent to the approval of claims hereunder, each Member authorizes and directs any Provider which furnished benefits hereunder to make available to CHL information relating to all treatment, copies thereof and other records as needed by CHL. CHL and any of its Designees shall have the right to release any and all records concerning health care services where are necessary to implement and administer the terms of the Rider or for appropriate medical review or quality assessment.

COVENTRY one

COVENTRY® Health Care
Coventry Health and Life Insurance Company

Check One
o New Enrollment **o** Change Form

Coventry Health and Life Insurance Company

Fax To: Coventry Health and Life Insurance Company
901-462-2385

[Coventry*One* Application / Health Statement Form]

A INDIVIDUAL INFORMATION (To Be Completed By Applicant)

Last Name	First Name	MI	M/F	Age	Birthdate / /	Social Security Number	Requested Effective Date

Address	Employer	Occupation/Title	Business Phone ( ) -	E-mail address

City	State	Zip Code	County	Home Phone ( ) -	Height (ft. in.)	Weight (lbs.)	Tobacco Use Yes/No

Benefit Selection – Please (circle) the benefit plan for which you are requesting coverage:

[Plus $1,000] [Plus $2,500] [Value $1,000] [Value $2,500] [Saver $1,500] [Saver $3,500]
[Plus $1,500] [Plus $3,500] [Value $1,500] [Value $3,500] [Saver $2,000] [Saver $5,000]
[Plus $2,000] [Plus $5,000] [Value $2,000] [Value $5,000] [Saver $2,500]

B FAMILY MEMBERS TO BE COVERED OR DELETED

Full Name (Last, First, MI)	Gender	Relationship	Age	Birthdate	Student or Disabled Dependent	SS Number	Height (ft.in.)	Weight (lbs.)	Tobacco Use Yes/No
	M / F	**SELF**		/ /	-------	- -			
	M / F	SPOUSE		/ /	-------	- -			
	M / F			/ /	S / D	- -			
	M / F			/ /	S / D	- -			
	M / F			/ /	S / D	- -			
	M / F			/ /	S / D	- -			

Are you, or anyone else applying for coverage, required to provide health care coverage for a child pursuant to a Qualified Medical Child Support Order or other court order? o No o Yes

If yes, please list the children.

Child's Name
1. _____
2. _____
3. _____
4. _____

Responsible Party
_____
_____
_____
_____

C PRODUCT SELECTION

TMJ Treatment – Applicant elects to provide coverage for Medically Necessary treatment related to musculoskeletal disorders affecting any bone or joint in the face, neck, or head, including temporomandibular joint disorder (TMJ) and craniomandibular disorder (CMD). (AR Code 23-79-150). **o** No **o** Yes

D OTHER HEALTH INSURANCE

Do you have other health coverage? **o** No (Skip to section E) **o** Yes (Complete this Section)

Policyholder Name	Policyholder Birthdate / /	Name of Insurance Company	Contract # / Group #	Policy Eff Date / /	Policy Term Date / /

Anyone applying for coverage hereunder having other health coverage must cancel that other health coverage upon our acceptance of the application for Coventry*One*. If the other health coverage is not cancelled, we will terminate Coventry*One* coverage back to your original effective date.

Is anyone applying for coverage hereunder covered by or eligible for coverage under Medicare? o No o Yes

E PREMIUM PAYMENT

Premiums due for coverage under this policy will be paid from funds deducted from either your checking or savings account. This withdrawal is done with your authorization and approval, pending final medical underwriting, an approved premium and your acceptance of coverage. To facilitate the monthly premium withdrawal we need your banking information. Providing this information does not guarantee coverage and no funds will be drawn prior to notification and acceptance by applicant.

Please Provide: **o** Checking Account **o** Savings Account

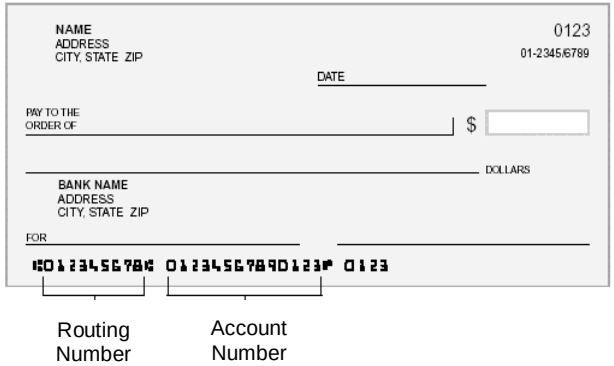
Name of Bank or Saving Institution: _____

Routing Number _____ Account Number _____
(A voided check or savings account deposit slip may be attached in support of content in this section)

Address of Bank _____

Name that appears on the Account _____

Address on the Account _____



Frequency of Transaction: Monthly Transaction Date: 10th Day of each Month

Your policy/coverage will be in effect when the premium rate has been presented and accepted, medical underwriting completed and approved, and premium payment received and applied to your account. By signing below, I authorize Coventry Health and Life Insurance Company to initiate automatic withdrawal of applicable premium payments from the account listed above. **I understand that it is my responsibility to notify the Plan if I change banks or account numbers.**

Accountholder Signature_____Date_____

F [HEALTH SAVINGS ACCOUNT ("HSA") OPTION FOR QHDHP ONLY

Your Health Savings Account ("HSA") is your financial asset even if you change health plans or are no longer covered by Coventry*One*. To open an HSA you must meet three criteria:

1) You must be covered by a Qualified High Deductible Health Plan (QHDHP)

2) You cannot be covered by another health plan, including Medicare

3) You cannot be claimed as a dependent on another individual's tax return

If you have selected a Coventry*One* Qualified High Deductible Health Plan (QHDHP) and are otherwise eligible, you will receive a Health Savings Account (HSA) through our HSA trustee, HealthEquity, at no additional charge. You will be able to contribute to this tax-advantaged account to help you put aside money to fund your medical claims before meeting your deductible and save for future medical expenses. As an additional benefit, HealthEquity will provide 24/7 telephonic support and online information to help you better manage this account. If you have selected a Coventry*One* QHDHP product and **do not want** to take advantage of the HSA account, please check the box below. Otherwise you will receive a welcome kit and HSA Debit Card from HealthEquity once your Coventry*One* QHDHP application is accepted.

o OPT–OUT of having an HSA opened through HealthEquity]

G HEALTH HISTORY — Please check Yes or No and provide details for all Yes answers below.

Within the past five (5) years have you or anyone else applying for coverage consulted or sought medical treatment, been diagnosed, had medical treatment recommended, received medical treatment or therapy, been surgically treated or been hospitalized for any of the following conditions? Incomplete applications may be rejected or returned to you or anyone else applying for coverage for completion.

1. Heart attack, heart murmur, irregular heart rate, stroke, chest pain, high blood pressure, angioplasty, heart bypass, rheumatic fever, congestive heart failure, heart or valve disorder?	Yes **o** No **o**	11. Donor, recipient or a candidate for a transplant? When? _____	Yes **o** No **o**
2. Hyperlipidemia, high cholesterol, arteriosclerosis, circulatory or vascular problems, hemophilia, blood clots, anemia, blood vessels or bleeding disorder?	Yes **o** No **o**	12. Any amputations, prosthetic devices or implants?	Yes **o** No **o**
3. Stomach or intestinal ulcer, colitis, Crohn's disease, hernia, hepatitis, liver disease or disorder of the stomach, intestines, pancreas, rectum or gall bladder?	Yes **o** No **o**	13. Any immune deficiency disorder, HIV, AIDS or AIDS-related complex?	Yes **o** No **o**
4. Cancer, cysts, polyps, tumor or growth of any kind?	Yes **o** No **o**	14. Any neurological or muscular disorders such as Cerebal Palsy, Multiple Sclerosis, Muscular Dystrophy or Parkinson's Disease?	Yes **o** No **o**
5. Disorder of the kidneys, prostate or urinary system, kidney failure, blood or albumin in urine or receiving dialysis?	Yes **o** No **o**	15. Have you been treated in the emergency room, been hospitalized or had any surgery in the past 5 years?	Yes **o** No **o**
6. Tuberculosis, emphysema, cystic fibrosis, COPD, bronchitis, asthma, allergies, sleep apnea, pneumonia, pleurisy, deviated nasal septum or disorder of the lungs or respiratory system?	Yes **o** No **o**	16. Manic depression, bipolar, panic attacks, schizophrenia, obsessive-compulsive disorders (OCD), depression or behavioral disorder?	Yes **o** No **o**
7. Epilepsy, any seizure disorder, Alzheimer's disease, fainting spells, migraines, frequent headaches, attention deficit disorders, paralysis, brain or neurological disorders? If epileptic, date of last seizure: _____	Yes **o** No **o**	17. Cataracts, glaucoma, macular degeneration, retinopathy, strabismus, eye disorders, ear infections, ear disorder or hearing impairment?	Yes **o** No **o**
8. Lupus, fibromyalgia, arthritis, fractures, back or spinal conditions, or disorder of the joints, muscles or bones?	Yes **o** No **o**	18. Thyroid, pituitary or adrenal gland disorder?	Yes **o** No **o**
9. Any bodily injury, concussion, burns, congenital problems or defects? Lyme disease or any chronic infections or infectious diseases?	Yes **o** No **o**	19. Sexually transmitted disease, abnormal pap smear or mammogram, breast disorder, disorder of male or female organs or menstrual dysfunction? Date of last menstrual cycle:_____.	Yes **o** No **o**
10. Diabetes or abnormal glucose test (high / low)? If diabetes, Type: _____ Any complications? _____	Yes **o** No **o**	20. Currently taking prescription medication(s) or receiving injection therapy?	Yes **o** No **o**

21. Is any male or female applicant pregnant or an expectant parent? (this includes the process of adoption or surrogacy). Due date? _____ Whom? _____	Yes **o** No **o**	24. Anorexia, bulimia, gastric bypass or other eating disorders?	Yes **o** No **o**
22. Been treated, counseled, or advised to seek treatment regarding use of alcohol, illegal substance, narcotics or prescription drugs?	Yes **o** No **o**	25. Had an X-ray, electrocardiogram, cardiac catheterization, MRI, CT scan, ultrasound or other diagnostic test or procedure, if "yes" what was the purpose?	Yes **o** No **o**
23. Sought or been advised to seek psychiatric, psychological or mental health treatment or counseling?	Yes **o** No **o**	26. Have you used tobacco products in the past 12 months? If Yes, what kind? _____ Frequency: _____ Whom? _____	Yes **o** No **o**
27. Any skin disorders such as psoriasis, acne, eczema, dermatitis, herpes, shingles or severe scars?			Yes **o** No **o**
28. Any pending or recommended surgery or procedure not yet performed, or have been advised to obtain equipment or services?			Yes **o** No **o**

29. List any disease, condition or impairment not mentioned above.

30. Please describe any holistic, alternative, natural treatment or remedies in the past twelve (12) months.

31. Applicant Name: _____

List last three blood pressure readings, if applicable: _____ _____ _____

List last three cholesterol readings, if applicable: _____ _____ _____

List last three blood sugar readings, if applicable: _____ _____ _____

32. Please list any medication you or any one else applying for coverage are currently taking, or have taken in the past 12 months, including injection therapy.

Applicant Name:_____

Name of Medication	Dosage	Prescribing Physician

33. Name of applicant's current physician Address Phone # Date and reason last consulted?

34. Name of dependent's current physician Address Phone # Date and reason last consulted?

35. Have you or any member of your family previously been insured by a Coventry Health Plan? **o** No **o** Yes Whom:_____

If you answered "Yes" to any of the previous medical questions, you and anyone else applying for coverage must complete the requested information about those conditions. Please explain and provide FULL DETAILS for each "Yes" answer to any condition(s) checked in the preceding boxes. Please give details on the last doctor visit and/or physical examination regardless of date or reason. Insert additional sheets if necessary.

Name of Applicant: ____

Question #	Condition or Diagnosis	Date of Onset/Treatment (Month/Year) Date Ended Still Under Treatment? o No o Yes	
Treatment Rendered		Medication (if taken)/ Date Prescribed/ Dosage	
Name of Hospital, Clinic or person providing care		Address	Phone #

Question #	Condition or Diagnosis	Date of Onset/Treatment (Month/Year) Date Ended Still Under Treatment? o No o Yes	
Treatment Rendered		Medication (if taken)/ Date Prescribed/ Dosage	
Name of Hospital, Clinic or person providing care		Address	Phone #

Question #	Condition or Diagnosis	Date of Onset/Treatment (Month/Year) Date Ended Still Under Treatment? o No o Yes	
Treatment Rendered		Medication (if taken)/ Date Prescribed/ Dosage	
Name of Hospital, Clinic or person providing care		Address	Phone #

Question #	Condition or Diagnosis	Date of Onset/Treatment (Month/Year) Date Ended Still Under Treatment? o No o Yes	
Treatment Rendered		Medication (if taken)/ Date Prescribed/ Dosage	
Name of Hospital, Clinic or person providing care		Address	Phone #

H CONDITIONS OF ENROLLMENT

I agree to enroll and to consent that Coventry Health and Life Insurance Company or its authorized representatives (collectively referred to as "Health Plan") may use or disclose to third parties the information contained on this enrollment form and individually identifiable health information relating to me or anyone applying for coverage for purposes of administering my health insurance benefit, including for treatment, payment or health care operations, as those terms are explained in detail in Health Plan's Notice of Privacy Practices and to the extent permitted by law.

I also agree that, to the extent permitted by law, health care providers, insurers, claims administrators, employers and others may disclose my personal information including individually identifiable health information that may include diagnosis, prognosis, treatment, and payment information related to physical and/or mental illness, including substance abuse, autoimmune deficiency syndrome (AIDS), AIDS related complex, human immunodeficiency virus (HIV) or genetic conditions to Health Plan for Health Plan's administration of health insurance benefits, including for treatment, payment or health care operations purposes and other purposes permitted by law.

I represent that all information on this application form is complete and accurate to the best of my knowledge. I understand that my answers to the questions on this form will be used to determine eligibility for coverage and is the basis on which my premium rate may be determined. I further understand that if any information is omitted or misrepresented, it could provide the basis to refuse or rescind coverage and to refund any premiums paid as though coverage had never been in force. After coverage has been in force for two years, no statement except fraudulent statements I make voids my coverage or reduces my benefits.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false, incomplete or misleading information in an application for insurance for the purposes of defrauding the company may be guilty of a crime and may be subject to denial of coverage, fines and confinement in prison.

NOTICE – YOU MUST PERSONALLY BEAR ALL COSTS IF YOU UTILIZE OUT-OF-NETWORK NON-EMERGENCY HEALTH CARE NOT AUTHORIZED BY THIS PLAN OR PURCHASE DRUGS WHICH ARE NOT AUTHORIZED BY THIS PLAN.

If applicant is under the age of 18, this application must be signed by the applicant's parent or legal guardian.

Applicant's Signature_____ Date_____ Relationship _____
If signed by someone other than the applicant.

Applicant Spouse's Signature_____ Date_____

Applicant's Signature_____ Date_____
Dependent Age 18 or Older

Applicant's Signature_____ Date_____
Dependent Age 18 or Older

Applicant's Signature_____ Date_____
Dependent Age 18 or Older

I APPLICATION COMPLETION

If you received assistance completing this application, please list the person or insurance producer who did so.

Name of Broker _____ Broker ID Number _____

Signature of Broker _____ Name of Agency _____

SERFF Tracking Number:	*GHPI-125840691*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Company*	*State Tracking Number:*	*40412*
Company Tracking Number:	*INDPPO08CHL*		
TOI:	*H15I Individual Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15I.001 Health - Hospital/Surgical/Medical Expense*
Product Name:	*AR Individual PPO*		
Project Name/Number:	*/*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*GHPI-125840691*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Company*	*State Tracking Number:*	*40412*
Company Tracking Number:	*INDPPO08CHL*		
TOI:	*H15I Individual Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15I.001 Health - Hospital/Surgical/Medical Expense*
Product Name:	*AR Individual PPO*		
Project Name/Number:	*/*		

Supporting Document Schedules

Review Status:

Satisfied -Name: Certification/Notice — Approved-Closed — 10/07/2008

Comments:

Attached is the readability certification for this product. Rules #19 & 49 appear to apply to group filings, so does not apply here. This is is a filing for individual coverage.

A cover letter and document list are also attached.

Attachments:

AR-Readability Certificate.pdf
AR PPO IND Initial Cover Ltr.pdf
AR-CHL Document List 100108.pdf

Review Status:

Satisfied -Name: Application — Approved-Closed — 10/07/2008

Comments:

Application for coverage is attached here and also under the "Form Schedule" tab.

Attachment:

CHAR 00007.pdf

Review Status:

Bypassed -Name: Outline of Coverage — Approved-Closed — 10/07/2008

Bypass Reason: The outline of coverage will be filed under separate cover.

Comments:

READABILITY CERTIFICATION

I hereby certify that the following forms comply with the Arkansas minimum Flesch reading ease test scores pursuant to A.C.A. § 23-80-206:

AR_PPOCOCIND_08_CHL
AR_MHIND_08_CHL
AR_RX08IND_CHL
AR_SOBIND_08_CHL
AR_TMJ_08_CHL
CHAR 00007

Jonathan Weinberg

(Signature) Assistant Secretary, Coventry Health & Life Insurance Company

Jonathan D. Weinberg

(Print Name)

September 30, 2008

(Date)

(314) 506-1928
acarter@cvty.com

October 1, 2008

Rosalind Minor
Sr. Certified Rate & Form Analyst
Arkansas Insurance Department
Life and Health Division
1200 West Third Street
Little Rock, Arkansas 72201

Re: Tracking #: INDPPO08CHL
Forms: Individual PPO Certificate of Coverage, Schedule of Benefits, Riders, Application, and Rate Information

Dear Ms Minor:

I am writing on behalf of Coventry Health and Life Insurance Co. ("CHL") regarding submission of the above referenced documents outlined in the attached list.

The intended market for these documents is the individual market. These documents are new, rather than replacement documents. These documents will be issued to individuals.

In addition, please note the following:

1. A check in the amount of $50.00 will be sent under separate cover.
2. Readability Certificate is attached.
3. I certify that the benefits payable and administered comply with AR Bulletin 9-85.
4. With regard to use of the term "Certificate of Coverage" for an individual policy document as per comment #3 of the February 12, 2008 letter, this is an acceptable term for both group and individual documents. This term has been accepted by several other states for the individual product. If there is an Arkansas regulation forbidding the use of "Certificate of Coverage", please let me know.
5. Comment #7 of the February 12, 2008 letter states that the "….Department does not allow trend for factor increases." Please

clarify. If there is a regulation regarding this statement, please provide the regulation number.

Thank you for your assistance with this filing. If you have any comments or concerns, please contact me at (314) 506-1928.

Sincerely,

Anita J. Carter, RN
Manager, Regulatory Compliance

Enclosures

Documents filed 10/01/08

AR_PPOCICIND_08_CHLL	Certificate of Coverage (COC)
AR_SOBIND_08_CHL	Schedule of Benefits (SOB)
AR_TMJ_08_CHL	TMJ Rider
AR_MHIND_08_CHL	Mental Health Rider
AR_RX08IND_CHL	Prescription Drug Rider
CHAR 00007	Application/Health Statement Form

COVENTRY one

COVENTRY® Health Care
Coventry Health and Life Insurance Company

Check One
o New Enrollment **o** Change Form

Coventry Health and Life Insurance Company

Fax To: Coventry Health and Life Insurance Company
901-462-2385

[Coventry*One* Application / Health Statement Form]

A INDIVIDUAL INFORMATION (To Be Completed By Applicant)

Last Name	First Name	MI	M/F	Age	Birthdate / /	Social Security Number	Requested Effective Date

Address	Employer	Occupation/Title	Business Phone ( ) -	E-mail address

City	State	Zip Code	County	Home Phone ( ) -	Height (ft. in.)	Weight (lbs.)	Tobacco Use Yes/No

Benefit Selection – Please (circle) the benefit plan for which you are requesting coverage:

[Plus $1,000] [Plus $2,500] [Value $1,000] [Value $2,500] [Saver $1,500] [Saver $3,500]
[Plus $1,500] [Plus $3,500] [Value $1,500] [Value $3,500] [Saver $2,000] [Saver $5,000]
[Plus $2,000] [Plus $5,000] [Value $2,000] [Value $5,000] [Saver $2,500]

B FAMILY MEMBERS TO BE COVERED OR DELETED

Full Name (Last, First, MI)	Gender	Relationship	Age	Birthdate	Student or Disabled Dependent	SS Number	Height (ft.in.)	Weight (lbs.)	Tobacco Use Yes/No
	M / F	**SELF**		/ /	-------	- -			
	M / F	SPOUSE		/ /	-------	- -			
	M / F			/ /	S / D	- -			
	M / F			/ /	S / D	- -			
	M / F			/ /	S / D	- -			
	M / F			/ /	S / D	- -			

Are you, or anyone else applying for coverage, required to provide health care coverage for a child pursuant to a Qualified Medical Child Support Order or other court order? o No o Yes

If yes, please list the children.

Child's Name
1. _____
2. _____
3. _____
4. _____

Responsible Party
_____
_____
_____
_____

C PRODUCT SELECTION

TMJ Treatment – Applicant elects to provide coverage for Medically Necessary treatment related to musculoskeletal disorders affecting any bone or joint in the face, neck, or head, including temporomandibular joint disorder (TMJ) and craniomandibular disorder (CMD). (AR Code 23-79-150). **o** No **o** Yes

D OTHER HEALTH INSURANCE

Do you have other health coverage? **o** No (Skip to section E) **o** Yes (Complete this Section)

Policyholder Name	Policyholder Birthdate / /	Name of Insurance Company	Contract # / Group #	Policy Eff Date / /	Policy Term Date / /

Anyone applying for coverage hereunder having other health coverage must cancel that other health coverage upon our acceptance of the application for Coventry*One*. If the other health coverage is not cancelled, we will terminate Coventry*One* coverage back to your original effective date.

Is anyone applying for coverage hereunder covered by or eligible for coverage under Medicare? o No o Yes

E PREMIUM PAYMENT

Premiums due for coverage under this policy will be paid from funds deducted from either your checking or savings account. This withdrawal is done with your authorization and approval, pending final medical underwriting, an approved premium and your acceptance of coverage. To facilitate the monthly premium withdrawal we need your banking information. Providing this information does not guarantee coverage and no funds will be drawn prior to notification and acceptance by applicant.

Please Provide: **o** Checking Account **o** Savings Account

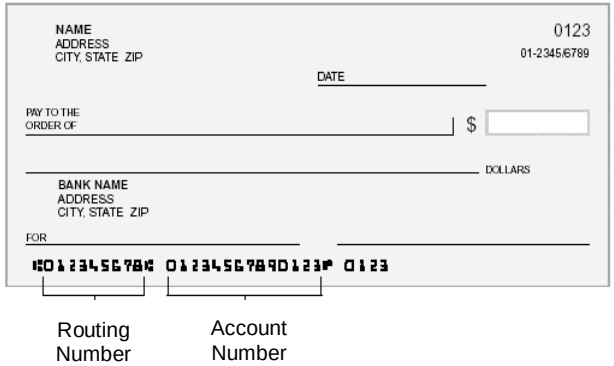
Name of Bank or Saving Institution: _____

Routing Number _____ Account Number _____
(A voided check or savings account deposit slip may be attached in support of content in this section)

Address of Bank _____

Name that appears on the Account _____

Address on the Account _____



Frequency of Transaction: Monthly Transaction Date: 10th Day of each Month

Your policy/coverage will be in effect when the premium rate has been presented and accepted, medical underwriting completed and approved, and premium payment received and applied to your account. By signing below, I authorize Coventry Health and Life Insurance Company to initiate automatic withdrawal of applicable premium payments from the account listed above. **I understand that it is my responsibility to notify the Plan if I change banks or account numbers.**

Accountholder Signature_____Date_____

F [HEALTH SAVINGS ACCOUNT ("HSA") OPTION FOR QHDHP ONLY

Your Health Savings Account ("HSA") is your financial asset even if you change health plans or are no longer covered by Coventry*One*. To open an HSA you must meet three criteria:

1) You must be covered by a Qualified High Deductible Health Plan (QHDHP)

2) You cannot be covered by another health plan, including Medicare

3) You cannot be claimed as a dependent on another individual's tax return

If you have selected a Coventry*One* Qualified High Deductible Health Plan (QHDHP) and are otherwise eligible, you will receive a Health Savings Account (HSA) through our HSA trustee, HealthEquity, at no additional charge. You will be able to contribute to this tax-advantaged account to help you put aside money to fund your medical claims before meeting your deductible and save for future medical expenses. As an additional benefit, HealthEquity will provide 24/7 telephonic support and online information to help you better manage this account. If you have selected a Coventry*One* QHDHP product and **do not want** to take advantage of the HSA account, please check the box below. Otherwise you will receive a welcome kit and HSA Debit Card from HealthEquity once your Coventry*One* QHDHP application is accepted.

o OPT–OUT of having an HSA opened through HealthEquity]

G HEALTH HISTORY — Please check Yes or No and provide details for all Yes answers below.

Within the past five (5) years have you or anyone else applying for coverage consulted or sought medical treatment, been diagnosed, had medical treatment recommended, received medical treatment or therapy, been surgically treated or been hospitalized for any of the following conditions? Incomplete applications may be rejected or returned to you or anyone else applying for coverage for completion.

1. Heart attack, heart murmur, irregular heart rate, stroke, chest pain, high blood pressure, angioplasty, heart bypass, rheumatic fever, congestive heart failure, heart or valve disorder?	Yes **o** No **o**	11. Donor, recipient or a candidate for a transplant? When? _____	Yes **o** No **o**
2. Hyperlipidemia, high cholesterol, arteriosclerosis, circulatory or vascular problems, hemophilia, blood clots, anemia, blood vessels or bleeding disorder?	Yes **o** No **o**	12. Any amputations, prosthetic devices or implants?	Yes **o** No **o**
3. Stomach or intestinal ulcer, colitis, Crohn's disease, hernia, hepatitis, liver disease or disorder of the stomach, intestines, pancreas, rectum or gall bladder?	Yes **o** No **o**	13. Any immune deficiency disorder, HIV, AIDS or AIDS-related complex?	Yes **o** No **o**
4. Cancer, cysts, polyps, tumor or growth of any kind?	Yes **o** No **o**	14. Any neurological or muscular disorders such as Cerebal Palsy, Multiple Sclerosis, Muscular Dystrophy or Parkinson's Disease?	Yes **o** No **o**
5. Disorder of the kidneys, prostate or urinary system, kidney failure, blood or albumin in urine or receiving dialysis?	Yes **o** No **o**	15. Have you been treated in the emergency room, been hospitalized or had any surgery in the past 5 years?	Yes **o** No **o**
6. Tuberculosis, emphysema, cystic fibrosis, COPD, bronchitis, asthma, allergies, sleep apnea, pneumonia, pleurisy, deviated nasal septum or disorder of the lungs or respiratory system?	Yes **o** No **o**	16. Manic depression, bipolar, panic attacks, schizophrenia, obsessive-compulsive disorders (OCD), depression or behavioral disorder?	Yes **o** No **o**
7. Epilepsy, any seizure disorder, Alzheimer's disease, fainting spells, migraines, frequent headaches, attention deficit disorders, paralysis, brain or neurological disorders? If epileptic, date of last seizure: _____	Yes **o** No **o**	17. Cataracts, glaucoma, macular degeneration, retinopathy, strabismus, eye disorders, ear infections, ear disorder or hearing impairment?	Yes **o** No **o**
8. Lupus, fibromyalgia, arthritis, fractures, back or spinal conditions, or disorder of the joints, muscles or bones?	Yes **o** No **o**	18. Thyroid, pituitary or adrenal gland disorder?	Yes **o** No **o**
9. Any bodily injury, concussion, burns, congenital problems or defects? Lyme disease or any chronic infections or infectious diseases?	Yes **o** No **o**	19. Sexually transmitted disease, abnormal pap smear or mammogram, breast disorder, disorder of male or female organs or menstrual dysfunction? Date of last menstrual cycle:_____.	Yes **o** No **o**
10. Diabetes or abnormal glucose test (high / low)? If diabetes, Type: _____ Any complications? _____	Yes **o** No **o**	20. Currently taking prescription medication(s) or receiving injection therapy?	Yes **o** No **o**

21. Is any male or female applicant pregnant or an expectant parent? (this includes the process of adoption or surrogacy). Due date? _____ Whom? _____	Yes **o** No **o**	24. Anorexia, bulimia, gastric bypass or other eating disorders?	Yes **o** No **o**
22. Been treated, counseled, or advised to seek treatment regarding use of alcohol, illegal substance, narcotics or prescription drugs?	Yes **o** No **o**	25. Had an X-ray, electrocardiogram, cardiac catheterization, MRI, CT scan, ultrasound or other diagnostic test or procedure, if "yes" what was the purpose?	Yes **o** No **o**
23. Sought or been advised to seek psychiatric, psychological or mental health treatment or counseling?	Yes **o** No **o**	26. Have you used tobacco products in the past 12 months? If Yes, what kind? _____ Frequency: _____ Whom? _____	Yes **o** No **o**
27. Any skin disorders such as psoriasis, acne, eczema, dermatitis, herpes, shingles or severe scars?			Yes **o** No **o**
28. Any pending or recommended surgery or procedure not yet performed, or have been advised to obtain equipment or services?			Yes **o** No **o**

29. List any disease, condition or impairment not mentioned above.

30. Please describe any holistic, alternative, natural treatment or remedies in the past twelve (12) months.

31. Applicant Name: _____

List last three blood pressure readings, if applicable: _____ _____ _____

List last three cholesterol readings, if applicable: _____ _____ _____

List last three blood sugar readings, if applicable: _____ _____ _____

32. Please list any medication you or any one else applying for coverage are currently taking, or have taken in the past 12 months, including injection therapy.

Applicant Name:_____

Name of Medication	Dosage	Prescribing Physician

33. Name of applicant's current physician Address Phone # Date and reason last consulted?

34. Name of dependent's current physician Address Phone # Date and reason last consulted?

35. Have you or any member of your family previously been insured by a Coventry Health Plan? **o** No **o** Yes Whom:_____

If you answered "Yes" to any of the previous medical questions, you and anyone else applying for coverage must complete the requested information about those conditions. Please explain and provide FULL DETAILS for each "Yes" answer to any condition(s) checked in the preceding boxes. Please give details on the last doctor visit and/or physical examination regardless of date or reason. Insert additional sheets if necessary.

Name of Applicant: ____

Question #	Condition or Diagnosis	Date of Onset/Treatment (Month/Year) Date Ended	Still Under Treatment? o No o Yes
Treatment Rendered		Medication (if taken)/ Date Prescribed/ Dosage	
Name of Hospital, Clinic or person providing care		Address	Phone #

Question #	Condition or Diagnosis	Date of Onset/Treatment (Month/Year) Date Ended	Still Under Treatment? o No o Yes
Treatment Rendered		Medication (if taken)/ Date Prescribed/ Dosage	
Name of Hospital, Clinic or person providing care		Address	Phone #

Question #	Condition or Diagnosis	Date of Onset/Treatment (Month/Year) Date Ended	Still Under Treatment? o No o Yes
Treatment Rendered		Medication (if taken)/ Date Prescribed/ Dosage	
Name of Hospital, Clinic or person providing care		Address	Phone #

Question #	Condition or Diagnosis	Date of Onset/Treatment (Month/Year) Date Ended	Still Under Treatment? o No o Yes
Treatment Rendered		Medication (if taken)/ Date Prescribed/ Dosage	
Name of Hospital, Clinic or person providing care		Address	Phone #

H CONDITIONS OF ENROLLMENT

I agree to enroll and to consent that Coventry Health and Life Insurance Company or its authorized representatives (collectively referred to as "Health Plan") may use or disclose to third parties the information contained on this enrollment form and individually identifiable health information relating to me or anyone applying for coverage for purposes of administering my health insurance benefit, including for treatment, payment or health care operations, as those terms are explained in detail in Health Plan's Notice of Privacy Practices and to the extent permitted by law.

I also agree that, to the extent permitted by law, health care providers, insurers, claims administrators, employers and others may disclose my personal information including individually identifiable health information that may include diagnosis, prognosis, treatment, and payment information related to physical and/or mental illness, including substance abuse, autoimmune deficiency syndrome (AIDS), AIDS related complex, human immunodeficiency virus (HIV) or genetic conditions to Health Plan for Health Plan's administration of health insurance benefits, including for treatment, payment or health care operations purposes and other purposes permitted by law.

I represent that all information on this application form is complete and accurate to the best of my knowledge. I understand that my answers to the questions on this form will be used to determine eligibility for coverage and is the basis on which my premium rate may be determined. I further understand that if any information is omitted or misrepresented, it could provide the basis to refuse or rescind coverage and to refund any premiums paid as though coverage had never been in force. After coverage has been in force for two years, no statement except fraudulent statements I make voids my coverage or reduces my benefits.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false, incomplete or misleading information in an application for insurance for the purposes of defrauding the company may be guilty of a crime and may be subject to denial of coverage, fines and confinement in prison.

NOTICE – YOU MUST PERSONALLY BEAR ALL COSTS IF YOU UTILIZE OUT-OF-NETWORK NON-EMERGENCY HEALTH CARE NOT AUTHORIZED BY THIS PLAN OR PURCHASE DRUGS WHICH ARE NOT AUTHORIZED BY THIS PLAN.

If applicant is under the age of 18, this application must be signed by the applicant's parent or legal guardian.

Applicant's Signature_____ Date_____ Relationship _____
If signed by someone other than the applicant.

Applicant Spouse's Signature_____ Date_____

Applicant's Signature_____ Date_____
Dependent Age 18 or Older

Applicant's Signature_____ Date_____
Dependent Age 18 or Older

Applicant's Signature_____ Date_____
Dependent Age 18 or Older

I APPLICATION COMPLETION

If you received assistance completing this application, please list the person or insurance producer who did so.

Name of Broker _____ Broker ID Number _____

Signature of Broker _____ Name of Agency _____